Traditional Healers and Mental Health Care in the South African Context

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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

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ABSTRACT

A number of African countries have made attempts to officially recognize traditional healers as health care providers and South Africa is no exception. South Africa has made substantial progress in officially recognizing traditional medicine and its integration into the primary healthcare system. The Traditional Health Practitioners Bill and the draft policy on African Traditional Medicine are examples of this. However, there is limited data on traditional healers and their practices specifically for mental health concerns. This thesis attempts to address this gap by conducting four separate studies.

The first study examines the role of traditional healers in mental health seeking behaviour within a nationally representative sample of South African adults. South Africans who suffer from psychiatric disorders are treated by both Western and alternative practitioners, including traditional healers. However there is limited data on the frequency and predictors of such consultation. The data for this study was taken from the South African Stress and Health Study (SASH). This national survey was conducted using the World Health Organization Composite International Diagnostic Interview (CIDI) to generate diagnoses based on the Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV), and included questions on treatment by Western and alternative practitioners. Results indicated that a minority of participants with a lifetime DSM-IV diagnosis obtained treatment from Western (29%) or alternative (20%) practitioners. Traditional healers were consulted by 9% of the respondents and 11% consulted a religious or spiritual advisor. Use of traditional healers in the full sample was predicted by older age, black race, unemployment, lower education and having an anxiety or a substance use disorder. In summary, alternative practitioners including traditional healers play an important role in the delivery of mental health care in South Africa. Although attention has previously been paid to the need for Western practitioners to collaborate with traditional healers in order to optimize health care in the country, the data here also emphasize the potential importance of working with religious and spiritual advisors.

Study 2 examines traditional healers' explanatory models (EMs) and treatment practices for psychotic and non-psychotic mental illnesses. In many traditional belief systems in Africa, including South Africa, mental health problems may be attributed to the influence of ancestors or bewitchment. Traditional healers are viewed as having expertise to address these

causes. However, there is limited information on their explanatory models and consequent treatment practices. Focus group discussions and in-depth interviews were conducted with 50 traditional healers. One vignette for each of the following disorders was presented: schizophrenia, depression, panic and somatisation. Results indicated that traditional healers held multiple explanatory models for psychotic and non-psychotic disorders; including bewitchment, physical diseases, stress, and "thinking too much". Psychotic illnesses appear to be the main exemplar of mental illness, while non-psychotic illnesses were not viewed as mental illness at all. In addition, although the healers report using herbs and substances from "traditional sources", they have also incorporated "modern" ingredients into their treatment practices. Interventions aimed at increasing the mental health literacy and improving the referral practices of traditional healers may be important to ensure mentally ill South Africans receive optimal treatment.

Study 3 evaluates the effectiveness of interventions for educating traditional healers in the fundamentals of STI and HIV medicine using the Cochrane methodology. Various intervention strategies have been adopted to educate traditional healers in various aspects of Western medicine, with a particular focus on HIV and AIDS. However, no systematic review has thus far attempted to determine whether interventions to educate traditional healers in HIV and STI medicine result in positive outcomes, such as an increase in knowledge. The present study conducted such a review using the methodology of the Cochrane Collaboration. All intervention studies using a controlled design (Randomised controlled trials (RCTs), controlled clinical trials (CCTs), or controlled before and after studies (CBAs) that have evaluated the effect of interventions on any one of the outcome measures specified were included. Two reviewers independently assessed the eligibility of potentially relevant studies. Data from included studies was extracted and the quality of the studies assessed. Two studies (one RCTs and one CBA study) were included in this review. However, a meta-analysis of study outcomes was not possible given the small number of included studies and the heterogeneity in methodological designs and outcome measures. Consequently, the results are presented in a narrative format. More rigorous studies (i.e. those employing rigorous randomisation procedures, reliable outcome measures and larger sample sizes) are needed to provide better evidence of the impact of HIV training programs aimed at traditional healers.

Study 4 aims to apply the Theory of Planned Behaviour (TPB) to predict traditional healer referral practices of mentally ill patients. Although many studies indicate that traditional healers are willing to collaborate with Western practitioners in South Africa, none focus

specifically on mental health care, and none use a theory of health behaviour to explain their findings. The aim of the present study is to apply the Theory of Planned Behaviour (TPB) to predict traditional healer referral practices of patients with mental illness. This two phase study attempts to fill this gap. In Phase 1, three focus groups with 24 traditional healers were conducted to elicit the indirect measures of the TPB, including common beliefs about referring, advantages and barriers to referring, and groups or institutions that would influence their decision to refer their patients. Results indicated that traditional healers do have a concept of mental illness that includes a patient behaving abnormally and often report regularly treating patients suffering from this. Additionally, traditional healer referral to Western care is considered a temporary measure or as a last resort. A majority feel that Western doctors do not treat them with the respect that they feel their contribution to the health of the community warrants. Recommendations include the need for traditional healers to be trained to identify potential cases of mental illness in their communities and a need for dialogue between traditional and Western practitioners in regard to mental health care. The results of this phase were used to develop the questionnaire used in phase 2. *In Phase 2,* 100 traditional healers were interviewed to assess the TPB variables (attitudes, subjective norms, perceived behavioural control) relevant to intentions to refer mentally ill patients, with the addition of a measure of past referral behaviour and knowledge of mental illness. In order to measure self-reported behaviour, all traditional healers were contacted 5 months following the initial interview. Herbalists were less likely than other types of healers to refer patients with a mental illness to Western health professionals. Attitudes, (ß = 0.612, $p < 0.01$); perceived behavioural control (ß = 0.355, $p < 0.01$), and past behaviour (ß = 0.704, $p < 0.01$) predicted intentions. On the other hand, subjective norms and knowledge of mental illness did not predict intentions. Past behaviour (ß = 0.297, $p = 0.040$) and intentions to refer patients (ß = 0.758, $p< 0.01$) predicted greater self-reported behaviour. The findings of this study show the potential for the TPB to be a useful theoretical model for predicting the referral practices of traditional healers. The empirical data here may be useful for future work in designing interventions to provide traditional healers with the information and skills they require to appropriately refer patients with mental illness.

In conclusion, this thesis has examined some key questions about the role of traditional healers in providing mental health services. Results indicated alternative practitioners including traditional healers and religious advisors are frequently consulted by South Africans, and hold multiple explanatory models for psychotic and non-psychotic disorders. At the present time, it is unknown whether interventions to educate traditional healers in HIV

and STI medicine are efficacious. However, there is potential for the TPB to be a useful model in predicting the referral practices of traditional healers. The main limitations of this study are that the interviews were conducted in African languages that I do not speak, and I was most likely considered an outsider by the traditional healers interviewed. Additionally, the results of all the studies, with the exception of study 1, cannot be generalized to the South African traditional healer population since convenience samples were utilized. Future research should also focus on replicating these studies using larger samples that represent traditional healers from various regions across South Africa. Training programs to increase the mental health literacy and referral practices of traditional healers should be developed and the effectiveness of the program assessed.

PREFACE

I wish to express my sincere appreciation to my two supervisors, Prof. Dan Stein and Prof. Alan Flisher, for their guidance and expert advice. I would also like to thank Ms. Anna Grimsrud and Dr. Landon Myer who provided the statistical expertise required to complete study 1 of this thesis. Additionally, this thesis would not have been completed without the support, encouragement, motivation and assistance I had from Ms. Zane Wilson, the founder of the South African Depression & Anxiety Group (SADAG) and the many SADAG trainers who helped me along the way. I would especially like to mention Mrs. Sue Watermeyer and Cindy Van Wyk for meticulously proofreading the chapters, and to my family and close friends who provided constant support, especially my partner Iain, and my parents Neil and Leslie.

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This thesis incorporates work reported in the following papers:

i. Sorsdahl, K., Stein, D.J., Grimsrud, A., Seedat, A., Flisher, A.J., Williams, D.R & Myer. L (2009). Traditional healers in the treatment of common mental disorders in South Africa. *Journal of Nervous and Mental Disease*, 197(6), 434-41.

ii. Sorsdahl, K., Stein, D.J., & Flisher, A.J. (2009). Explanatory models of mental disorders and treatment practices among traditional healers in Mpumulanga, South Africa. *Transcultural Psychiatry* (submitted).

iii. Sorsdahl, K., Flisher, A.J., & Stein, D.J. (2009). Traditional healer attitudes and beliefs regarding referral of mentally ill adult and adolescent patients to Western doctors in the Eastern Cape, South Africa. *Transcultural Psychiatry* (submitted).

iv. Sorsdahl, K., Ipser, J., & Stein, D.J. (2009). Interventions for educating traditional healers about STD and HIV medicine. *Cochrane Library* (submitted).

v. Sorsdahl, K., Flisher, A.J., & Stein, D.J. (2009). Predicting referral practices of traditional healers of their mentally ill adult and adolescent patients: an application of the theory of planned behaviour. *Health Education Research* (submitted).

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CHAPTER 1

INTRODUCTION

1.1 Context

Mental disorders and their associated psychosocial disabilities are a source of considerable morbidity and impose a significant drain on national resources (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006). Results from the WHO World Mental Health Consortium demonstrate that common mental disorders are highly prevalent in both the developed and the developing world (Demyttenaere et al., 2004). The majority of the world's 450 million people who suffer from psychiatric morbidity live in developing countries, and less than 10% have access to mental health care (WHO, 2001a).

Results from the South African Stress and Health Study, the first nationally-representative study of psychiatric morbidity in South Africa, indicate that approximately 30% of adults have experienced a DSM-IV disorder in their lifetime; this includes 16% with an anxiety disorder, 10% with a mood disorder and 13% with a substance use disorder (Stein et al., 2008). Most South Africans have limited access to psychiatric care. Lund and Flisher (2002) documented the number of mental health professionals employed in the public sector. They distributed a questionnaire to provincial mental health co-ordinators and followed this up with visits to each of the nine provinces. They then calculated staff: population ratios, using data from the 1996 census in the denominators. They found that the overall staff/population ratio in the public sector mental health services was 19.5 per 100,000, with an inter-provincial range of 5.7 to 31.5 per 100,000. SASH found that only one-quarter of South Africans with a recent DSM-IV diagnosis received treatment in the year preceding the interview (Wang et al., 2007).

Several studies confirm that traditional healers are frequently consulted in South Africa for mental health problems. Studies estimating the proportion of South African patients that have consulted a traditional healer range from 41% to 75% (Ensink & Robertson, 1999; Freeman, 1992; Freeman, Lee, & Vivian, 1994). One central reason that traditional healers are consulted is that they offer treatments that are congruent with the culture of the patients seeking treatment (Freeman et al., 1994; Mbanga, Niehaus, & Mzamo, 2002; Nattrass, 2005; Patel, Simunya, & Gwanzura, 1997). In many traditional African belief systems, mental health problems are attributed to ancestors or bewitchment, and traditional healers are viewed

as having expertise to address these causes. Furthermore, traditional healers are often more accessible than Western mental health care. It has been estimated that there are at least 200 000 traditional healers in South Africa (or aproximately 1 per 500 South Africans) (Abdool Karim, Ziqubu-Page, & Arendse, 1994)

1.2 Background

1.2.1 Mental Health in the Developing World

In 2000, mental disorders accounted for 12% of the global burden of disease. This figure is expected to rise to 15% in 2020, when it is estimated that unipolar depression will be the second most disabling health condition in the world (Lopez et al., 2006) According to the WHO projection, the burden of mental illness is escalating in developing countries, which is also where mental health resources are most scarce (WHO, 2005).

In many developing countries, mental health is assigned a low priority (Saxena, Sharon, & Saraceno, 2003). For example, as part of the Project Atlas, the World Health Organization (WHO) collected information from 191 countries. Of the 191 countries, 32% did not have a dedicated budget for mental health services. Countries in the African (79%) and South East Asian regions (63%) spent less than 1% of their health budget on mental health (Saxena et al., 2003). This may be partly due to the devastating effects of communicable diseases in these areas, resulting in the healthcare priorities being focused on such diseases (Gureje & Alem, 2000).

Although infectious diseases result in high mortality figures, mental disorders and their associated psychosocial disabilities are also a source of considerable personal suffering, and impose a significant drain on national resources (McGrath & Tariq, 1997). According to the World Development Report (WDR), mental health problems are one of the largest causes of "Disability Adjusted Life Years" – accounting for 8.1% of all lost years (World Bank, 1993). Conversely, if an individual is in a state of optimal mental health, they are enhancing human (individual productivity) and social capital (social cohesiveness).

Although healthcare and living conditions improved between 1945 and 1995, this was not the case for mental health (Desjarlais, Eisenberg, Good, & Kleinman, 1995). Recently, international and national mental health initiatives by the WHO, UNESCO, World Bank, and Global Forum have been successful in raising the awareness of the importance of mental

health, and have provided guidance for low-income countries (Abas, Broadhead, Mbape, & Khumalo-Sakatukwa, 1994). In 2001, WHO committed its World Health Day to the issue of mental health, and the World Health Assembly dedicated its' meeting exclusively for discussions concerning mental health. Furthermore, WHO's annual World Health Report was devoted exclusively to mental health (WHO, 2001), and the Lancet series on global mental health was launched in 2007. This series consisted of five articles documenting the evidence base for global mental health, with a focus on low and middle income countries (The Lancet Global Mental Health Group, 2007). The Series has received worldwide interest including endorsements from leading institutions such as the World Federation for Mental Health, the WHO and the World Psychiatric Association.

Nonetheless, despite evidence that mental health disorders are being addressed, this is by no means a promise that the quality of life of patients suffering from these disorders in developing countries will improve in the near future. Instead, this new found interest and enthusiasm for combating these debilitating disorders should be seen as an opportunity for action to be taken in improving mental health worldwide, with a particular focus on developing countries. Many countries, including South Africa, have many obstacles to overcome if they are going to meet the mental health requirements of their country. As in any other developing country, South Africa has a high incidence of some of the risk factors for poor mental health—violence, poverty and HIV.

1.2.2 Mental Health Care in South Africa

During apartheid, the mental health service planning that occurred was unsystematic and services that were provided were uncoordinated. Custodial care was in large institutions and primarily for the severely ill (Foster, Freeman, & Pillay, 1977). The approach was curative and residual rather than developmental and preventative (Freeman, 1992). Furthermore, racial discrimination, paternalism and some degree of privatization were common features of mental healthcare services in South Africa (Foster et al., 1977). Evidence of the inhumane practices in psychiatric facilities was reported when a delegation from the American Psychiatric Association (APA) visited South Africa. The organization compiled a report criticizing racial bias in psychiatric practice by pointing out the destructive impact of apartheid on the mental health of Black South Africans. It appears that mental health services in South Africa simply reflected the injustices and discrimination of the society in which they have been embedded (Foster et al., 1997). However, in response to these honest, although negative findings,

government officials accused these American psychiatrists of promoting the special interests of certain anti-Apartheid pressure-groups (Domissee, 1987).

In response to the high prevalence of psychiatric morbidity and the increased attention mental health has been receiving in South Africa, the South African government has prioritised mental illness on the country's agenda. Democratization in 1994 and the introduction of a White Paper for the Transformation of the Health System in South Africa (DOH, 1997), provided a basis for more accessible, unbiased, and community-centred mental health services. In 1997, the Department of Health adopted national "policy guidelines" for mental healthcare in the country, although has not yet formally adopted a national health policy (Lund et al., 2008).

More recently, the Mental Health Care Act No. 17 of 2002 took concerns over mental health a step further with the aim to include mental health as a public issue and concurrently protecting the human rights of those suffering from a mental illness. The Mental Health Care Act is based on consultation with numerous stake-holders in the country and is consistent with human rights standards on an international level (Lund et al, 2008). Although the Mental Health Care Act (2002) is a step forward in prioritizing mental health care, it is driving changes in the provincial mental health services in the absence of clearly defined policy guidance and leadership from the Department of Health. To date, only four of the nine provinces in South Africa have a clearly identifiable strategic plan for mental health, despite the fact that mental health is defined as a priority in South Africa (Lund et al., 2008).

In order for South Africa to meet the needs of its population in terms of mental healthcare, major reforms of the mental health systems are required. Despite efforts in South Africa, racial and monetary inequality in psychiatric care continue to exist; services continue to be poorly developed in rural areas and available skills and personal are limited (Emsley, 2001). For example, a study investigating the professional activities of 261 psychiatrists in South Africa found that only 56.3% were employed in full-time private practice, 7% spent time working in rural areas, and only 10.8% could communicate in one or more African languages (Flisher, Riccitelli, Jhetam, & Robertson, 1997). Furthermore, a study conducted by Kohn, Niehaus, Muller, and Laurent (2003) examined psychiatrists' perceptions on the changes in the quality of psychiatric services five years after apartheid using a mail-out survey to 419 psychiatrists. Since the number of psychiatrists actually practicing in South Africa at this time was difficult to determine, so was the response rate. However, it may range from 25–30%. Results indicated that psychiatric care in South Africa is deteriorating and that the end of

apartheid has done little to improve quality of care. Over 60% of respondents reported that they believed racial inequalities still continue to exist 5 years following apartheid.

1.2.3 Traditional healers, mental health and South Africa

My interest in studying traditional healers originated from my involvement with the South African Depression & Anxiety Group (SADAG). I moved from Canada to South Africa specifically to work with this mental health advocacy group that has been active for over 12 years. Since 1997, SADAG has initiated rural development projects in communities that have few mental health services, and through their rural outreach work, they are actively involved in training traditional healers in psychosocial and basic mental health care. This focus on mental health care is particularly appealing given that the majority of the research and information existing on traditional healers focuses almost exclusively on infectious diseases such as HIV, tuberculosis (TB) and Malaria.

Through my involvement with SADAG, I have enjoyed the privilege of spending a substantial amount of time with the traditional healers. I have attended their cultural dances, visited them in their homesteads, and met members of the communities in which they play a key role. It became apparent that the healers (for the most part) are caring and dedicated people who develop a trusting relationship with their patients and hold similar goals to that of Western health care professionals. I regard traditional healers as an untapped resource that could potentially play a role in addressing the need for increased mental health services in South Africa - and this is also the principle behind SADAG's work with them. However, due to the lack of research into traditional healers and mental health care in South Africa the most effective method of utilizing these traditional healers remains unknown.

Even the term ‘traditional healer’ is an oversimplification of the extensive scope of their practices, since there are a range of different types of traditional healers in Sub-Saharan Africa. While their functions may overlap they are not considered to be a homogeneous group (Ensink & Robertson, 1996). The *diviners* are believed to be specialists in divination within the supernatural context which gives them the ability to divine the cause of illness and misfortune (Edwards, 1986). The *herbalist* specializes in the production of herbal medicines (Ngubane, 1977). *Faith healers* integrate Christian ritual and traditional practices, and belong to one of the Independent African churches (Edwards et al., 1983). Whether or not faith healers fit under the category of traditional healers is debatable as they place themselves at the

cusp between what has been referred to as the backward and outdated traditional healers and the modern, scientifically based Western medicine (Freeman & Motsei, 1992).

A number of small studies conducted in South Africa investigating individuals with a mental illness report that approximately one-half (41-61%) of patients have consulted a traditional healer (Ensink & Robertson, 1999; Freeman et al., 1994; Mkize & Uys, 2004). For example, in the Eastern Cape a study investigating a random sample of 62 African patients from first admissions to a large psychiatric institution in the Western Cape reported that that 61% of the patients had consulted indigenous healers during the 12 months preceding the study (Ensink & Robertson, 1999). These small studies employ a range of convenience sampling methods, leading to results that are difficult to generalise to the South African population as a whole. In turn, the extent to which traditional healers are consulted, and predictors of traditional healer visits, remains poorly understood. Reseach question #1 addresses this gap.

Research question #1

To what extent do patients suffering from a mental illness in South Africa consult traditional healers for their emotional and mental health care concerns?

One of the reasons traditional healers are widely consulted by mentally ill South Africans is that in many traditional African belief systems, mental health problems are attributed to ancestors or bewitchment, and traditional healers are viewed as having expertise to address these causes (Patel, 1995). Eliciting patient explanatory models is a key element when examining the role of culture on psychiatric disorders, predominantly in clinical research (Patel, 2000). The explanatory model framework is based on a social construction of reality. An explanatory model (EM) is defined by Kleinman (1980) to denote the 'notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process'. These models are linked to particular categories of illness, and reveal labels and cultural idioms for expressing the experience of illness (Kleinman, 1980).

According to the few studies conducted in Africa investigating the explanatory models (EMs) of mental illness, there appears to be a distinction between those of psychotic (e.g schizophrenia and bipolar disorder) and non-psychotic disorders (Aidooi & Harpham, 2001; Patel, 1996; Patel, Gwanzura, Simunyu, Lloyd, & Mann, 1995a; Patel, Musara, Butau, Maramba, & Fuyane, 1995b). Patel (1996) hypothesizes that many Africans are unable to

distinguish between non-psychotic and psychotic disorders, since many do not identify non-psychotic disorders as being related to mental illness. Whether there is enough data to support this view is debatable since only a few studies have been conducted addressing this issue, none of them recent, and few outside Zimbabwe. Drawing conclusions about "Africans" based on a few studies seems unwarranted. More specifically, there is presently a lack of studies investigating the explanatory models of traditional healers practicing in South Africa. Reseach question #2 addresses this gap.

Research question #2

What are the explanatory models of mental disorders among South African traditional healers?

Although genuine traditional healers hold paramount the well-being of their patients and communities, there is substantial evidence that the non-standard and unhygenic provision of traditional medicine has many implications for patients (Chipfakacha, 1997; Garba & Deshi, 1998; Green & Makhubu, 1984; Luyckx, Steenkamp, Rubel, & Stewart, 2004; Peters, Immananagha, Essien, & Okott, 2004). Interventions provided by traditional healers include herbal medication (which is ingested, rubbed into incisions or inhaled), simple surgical procedures (such as blood-letting, cupping and scarification), and rituals (such as introduction of enemas, vomiting, whistling, and animal sacrifices) (Asuni, 1979; Gumede, 1990). For example, cases of acute poisoning due to traditional medicines are not uncommon, and many of these have resulted in significant morbidity and mortality (Stewart, Steenkamp, & Zuckerman, 1998). All people have the right to medicines and treatment that are safe and efficacious and medicines, whether Western or traditional, should fulfil the same uniform standards, tests and trials before being made available to the public. There is presently a lack of studies investigating the treatment practices of traditional healers specifically for mental illness in South Africa. Reseach question #3 addresses this gap.

Research question #3

What are the specific treatment practices for mental disorders used by South African traditional healers?

Views on collaboration between traditional and Western medicine in South Africa vary substantially. For example, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) encourage Western medicine to understand traditional systems of care and supports collaborative efforts between these systems (WHO-UNICEF, 1978). The South African Medical Association (SAMA) believes this collaboration and integration will ensure an increase of safety standards (Abdool Karin & Ziqubu-Page, 2004). Robertson (2006) argues that collaboration should be promoted, but further knowledge and debate is required about the most appropriate way (specifically for mental health practitioners) to collaborate with traditional healers, and on what basis this should be founded.

On the other hand, Doctors for Life (DFL) (an international organization that represents a large number of medical doctors, dentists, veterinarians and other health professionals) are opposed to collaborating with traditional healers, arguing that many of their practices have been shown to cause considerable harm to patients. DFL advocates the promotion of holistic health, but states this should be done in a "scientifically sound and morally responsible way" (Doctors for Life, 2007).

Broadly speaking, there are three pathways for such collaboration between Western and traditional health care professionals: 'incorporation' which suggests that traditional healers be incorporated into the primary health care service where they can play the role of village health workers; 'co-operation' which implies that both traditional and Western health systems remain autonomous and each retains its own methods of operation and explanation; and 'total integration', in which a 'new' system of healing through the merging of the two different medicinal systems (Pillsbury, 1982). With the passing of the Traditional Health Practitioners Bill, and the recent development of the Traditional Health Policy, the South African government has opted for the co-operation approach (DOH, 2008).

It is acknowledged that current collaborative efforts between these two systems take on the form of a one-sided unidirectional, educative approach, with an emphasis on training traditional healers. A number of intervention strategies have been adopted to educate traditional healers in the fundamentals of a number of health care issues (e.g. STI and HIV medicine, TB, Malaria). However, whether or not they are effective remains unknown (Green 1994; Green, Zokwe, & Dupree, 1995; UNAIDS, 2000, 2002). To date, no systematic review has attempted to determine whether interventions to educate traditional healers result in positive outcomes, such as knowledge gain, behaviour change and referral of patients to

Western health professionals if they are not responding to traditional treatment. Reseach question #4 addresses this gap by focussing on studies related to HIV and AIDS.

Research question #4

Are interventions for educating traditional healers about STD and HIV medicine efficacious?

The South African Depression & Anxiety Group (SADAG), a mental health advocacy group presently active in South Africa has dedicated time and resources to working with traditional healers. Over the past 4 years SADAG has made efforts to educate traditional healers on mental health care issues in a 3-4 hour educational workshop. However, one of the main concerns NGO's are now facing is the importance of evaluating the effectiveness of programs when the outcomes of interest include constructs such as attitudes and behaviour change. Not to mention whether they actually have any effect on treatment. This is a challenge as constructs such as behaviour and attitude can be difficult to measure. However, social cognitive models, such as the Theory of Planned Behaviour (TPB) may contribute to the understanding of behaviours such as traditional healer referral practices (Ajzen, 1991).

Presently we are not aware of any attempts to utilize the TPB to gain a better understanding of traditional healers and their decision to refer their mentally ill patients who are not responding to treatment to a Western practitioner. Research question #5 addresses this gap.

Research question #5

What are the beliefs and attitudes associated with traditional healers and their decision to refer adolescents and adults suffering from a mental illness to a Western Practitioner?

It is hoped that the findings of this thesis will provide a better understanding of traditional healers and their beliefs, practices and contribution to mental health care in South Africa. My wish is that this understanding and new knowledge will be used to inform collaborative efforts between Western & traditional health practitioners leading to better access to mental health services for all South Africans.

1.3 Research Objectives

A number of key questions have been derived from the literature review (Chapter 2), and the answers lead directly to addressing the research questions. The objectives of this thesis are:

#1. To review the literature on traditional healers and their practices with respect to mental health care in Africa and the role of advocacy groups in the development of mental health care in South Africa.
#2. To determine the extent to which patients suffering from a mental illness in South Africa consult traditional healers for their emotional and mental health care concerns.
#3. To explore the explanatory models and beliefs related to psychiatric morbidity among traditional healers in rural South Africa.
#4 To determine the specific treatment practices for mental disorders used by South African traditional healers.
#5. To determine whether interventions for educating traditional healers about STD and HIV medicine are effective.
#6. To elicit the beliefs and attitudes associated with traditional healers and their decision to refer adolescents and adults suffering from a mental illness to a Western Practitioner.

1.4 Outline of this thesis

The thesis is structured as follows.
Chapter 2 reviews the literature that is relevant to each of the six research objectives. One contribution of Chapter 2 to the thesis is its derivation of the five research questions that guided the actual research.

Chapters 3, 4, 5 & 6 will answer each question proposed in this thesis as a separate study in turn, with the exception of the explanatory models and treatment practices of traditional healers being investigated in one chapter (chapter 4). Each chapter will justify the research methods and describe thoroughly how each study was conducted. It will contain the results of the primary data gathered by the author. The main findings will be discussed, in addition to limitations and potential areas for future research.

Chapter 7 draws on the accumulated evidence presented in Chapters 2, 3, 4, 5 and 6 to derive answers for the four research questions and also the research problem. It also presents implications for policy involving traditional healers, in addition to practice and training.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

While the previous chapter introduced the research questions this study will address, this chapter provides the background literature to the study. Its purpose will be to review the literature on traditional healers and their practices with respect to mental health care, and the role of advocacy groups in the development of mental health care in South Africa. There will be a focus on South African literature and mental disorders, but given the scarcity of research in this area, literature outside of South Africa, and work on general medical disorders, will be included. The following methods have been used to locate literature for this chapter: (1) searching the MEDLINE, PUBMED and PSYCHINFO databases (2) scanning the reference list in articles already located; and (3) suggestions from colleagues working in this field. The literature search was confined to English publications in peer review journals. Where unpublished works were encountered during this search, such as conference proceedings and unpublished reports, these have been included.

2.1.1 Chapter outline

The literature review in this chapter will commence by defining mental illness according to the DSM-IV, followed by a description of the existing literature available on the extent to which traditional healers are utilized in mental health care delivery in South Africa. Approaches to investigating cross cultural research and the concept of explanatory models in relation to mental health will be introduced. I will then describe traditional healers and their practices in general, and then will focus on the treatment practices specifically for mental health care. The potential of the Traditional Health Practitioners Bill to regulate the estimated 200 000 traditional healers in South Africa will also be addressed. Finally, the necessity for training and the benefits of existing training programmes in improving healers' knowledge and creating better-informed practices will be discussed.

The next section of this chapter changes focus to the role of advocacy groups in the development of mental health care in South Africa. Specifically, it will define the role of advocacy groups and their contribution to addressing barriers to mental health care such as mental health literacy and stigma. Five large mental health advocacy groups in South Africa will be introduced, with a focus on the South African Depression and Anxiety Group (SADAG). SADAG dedicates a great deal of its resources to rural outreach, including

educative workshops aimed at traditional healers. The potential for NGOs to collaborate with traditional healers in the mental health sector will be addressed, as well as the importance of developing interventions that are effective and theory-based. The use of the Theory of Planned Behaviour (TPB) to predict traditional healers' referral of mentally ill patients to Western practitioners will be discussed in addition to the implications of using such a model when designing interventions.

2.2 Mental Illness: A Worldwide Phenomena

Any attempt at describing the role of traditional healers in mental health, would not be complete without first looking at what is meant by mental illness. The following section therefore takes a brief look at the concept of mental illness according to the DSM-IV.

2.2.1 Mental Illness According to the DSM-IV

Mental health is an integral part of general health, which the WHO views as not just merely the absence of disease or ill-health but a complete state of physical, mental and social wellbeing (WHO, 1999). The term mental illness refers to all diagnosable mental disorders, which are health conditions characterized by abnormalities in mental functions. Mental disorders are displayed in varying degrees of intensity and duration, and it is possible for many signs of mental disorders to be present without meeting the full criteria of a mental disorder. The most severe of these disorders are triggered by a malformation of the brain or a malfunctioning of its complex electrochemical processes resulting in distorted thinking, feeling and behaviour (Kaplan & Sadock, 1997). The majority of mental disorders, like most illnesses, are caused by a combination of biological, environmental and psychological factors.

The two most widely used internationally recognized systems of classifying psychiatric diagnosis are the International Classification of Disease (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) (APA, 1994). Today, since the DSM offers more detailed diagnostic criteria compared to the ICD-10 which is oversimplified in this regard, it is common practice for mental health professionals and researchers to use the guidelines developed in the DSM. The DSM is a manual published by the American Psychiatric Association and is a categorical classification system covering all mental health disorders for both children and adults. The DSM has undergone numerous revisions since the first edition in 1952 (APA, 1994). The most recent edition is the revised version of the DSM-IV (fourth edition).

The DSM-IV is a comprehensive classification system that uses a descriptive approach. It aims to describe the manifestations of mental disorders without placing too much emphasis on the causes or development of disease (Kaplan & Sadock, 1997). Diagnosis is therefore based on specific diagnostic criteria for each specific mental disorder. The diagnostic criteria include a list of features that must be present and applicable for a diagnosis to be made. Although the DSM-IV does not emphasize the aetiology of the illness, it does provide extensive details of the known causes of the specific disorders, and other useful statistics which may help aid in diagnosis, such as gender, age of onset, and prognosis in addition to available research on the available treatment options.

The DSM-IV uses a multi-axial or multidimensional approach to diagnosing, as a person's mental health is always impacted by a variety of factors. The five dimensions below outline this approach to diagnosis: All mental disorders fall within Axis I and Axis II covering clinical disorders, personality disorders and mental retardation. The medical conditions that present together with the mental disorder(s) at the time of evaluation are listed on Axis III including infectious diseases, respiratory, heart or blood conditions and immunity or inherited disorders. Axis IV codes environmental and psychosocial stress factors such as financial, support system or occupational problems that have contributed to the condition. Finally, Axis V rates the overall functioning of the person on a 100-point scale where a score of 100 refers to superior functioning. This is referred to as the global assessment of functioning (GAF) scale which places diagnosis on a continuum of mental health and mental illness (APA, 1994). This holistic approach strengthened by the multi-axial system helps to identify the most effective and appropriate treatment strategy.

Table 2.1 The 5-axial classification system of the DSM

Axis	**Variable**
Axis I:	The main clinical (psychiatric) diagnosis.
Axis II:	Personality disorders/ traits, and mental retardation.
Axis III:	Co-existing medical conditions that have potential relevance to the management of the patient.
Axis IV:	Psychosocial and environmental problems that may play a role in the development or exacerbation of the psychiatric disorder.
Axis V:	Degree of impairment in social, occupational and psychological functioning currently, and in the past year.

(APA, 1994, pp 25-31)

The DSM system classifies mental disorders into a few broad categories including mood, anxiety, psychotic and personality disorders. A full list of disorders by category is included in Table 2.2. Often an individual symptom has an overlap with disorders in the same category and/or with disorders in other categories.

Table 2.2 DSM-IV diagnostic categories with selected psychiatric diagnoses

Main diagnostic category	**Mental disorder**
Disorders usually first diagnosed in infancy, childhood, or adolescence	Mental retardation Learning disorders Attention deficit and disruptive behaviour disorders
Delirium, dementia, and amnestic and other cognitive disorder	Delirium Dementia of Alzheimer's type Vascular dementia
Mental disorders due to a general medical condition (GMC) not elsewhere classified	Catatonic disorder due to a GMC Personality change due to a GMC
Substance-related disorders	Alcohol use disorders Cannabis use disorders Cocaine use disorders
Psychotic disorders	Schizophrenia Schizophreniform disorder Schizoaffective disorder
Mood disorders	Depressive disorders Bipolar disorders
Anxiety disorders	Panic disorder Obsessive-compulsive disorder Posttraumatic stress disorder
Somatoform disorders	Somatization disorder Conversion disorder Pain disorder
Factitious disorders	Factitious disorder with predominantly psychological signs and symptoms Factitious disorder with predominantly physical signs and symptoms
Dissociative disorders	Dissociative amnesia Dissociative fugue Dissociative identity disorder
Sexual and gender identity disorders	Sexual dysfunctions Paraphilias Gender identity disorders
Eating disorders	Anorexia nervosa Bulimia nervosa
Sleep disorders	Dyssomnias Parasomnias
Impulse-control disorders not elsewhere	Intermittent explosive disorder

classified	Kleptomania Pyromania
Adjustment disorders	Adjustment disorder with depressed mood Adjustment disorder with anxiety
Personality disorders	Paranoid personality disorder Antisocial personality disorder Narcissistic personality disorder

Of particular importance to the present study are mood, anxiety, psychotic, and somatoform disorders. Vignettes portraying a diagnosis within each of these four categories were drawn up using DSM-IV criteria and employed during the survey phase of the study assessing traditional healer explanatory models (see chapter 3). The diagnoses covered included schizophrenia, major depressive disorder, panic disorder and somatization disorder.

In South Africa a number of health professionals who fit under both the Western and traditional medicine categories are available to treat patients suffering from a mental illness. Pathways to mental health care in South Africa will now be discussed.

2.3 Pathways to Mental Health Care in South Africa

The following section will discuss pathways to mental health care in South Africa, focussing on the use of traditional healers for the treatment of mental illness. Additionally, studies assessing predictors of traditional healer consultation for mental health concerns will be addressed.

2.3.1 Traditional Healers in the Pathway to Mental Health Care

Results of small studies conducted in South Africa investigating individuals with a mental illness, report that approximately one-half (41-61%) of patients have consulted a traditional healer (Ensink & Robertson, 1999; Freeman et al, 1994; Mkize & Uys, 2004). For example, in the Eastern Cape a study investigating a random sample of 62 African patients from first admissions to a large psychiatric institution in the Western Cape reported that that 61% of the patients had consulted indigenous healers during the 12 months preceding the study (Ensink & Robertson, 1999). However, these have been small studies employing a range of convenient sampling methods, potentially with more severe disorders, leading to results that are difficult to generalize to the South African population as a whole.

Although there is a gap in the literature on predicting traditional healer use for mental health care needs in South Africa, studies conducted in Zimbabwe and Tanzania result in conflicting

findings. In Tanzania, 178 primary healthcare patients and 176 traditional healer patients were interviewed to determine the prevalence of common mental disorder and the characteristics of those consulting. Multivariate analysis indicated that being better educated, older, widowed or separated and being of Christian faith were independently associated with consulting a traditional healer (Ngoma, Prince, & Mann, 2003). In Zimbabwe, a different pattern emerged, after interviewing 302 patients attending primary care and traditional healers, in that the patients of traditional healers were more likely to be female and also to be unemployed, with less education (Patel et al., 1997).

However, the extent to which traditional healers are consulted, and predictors of traditional healer visits in South Africa remains poorly understood. To date, there are no population-based estimates of the use of traditional healers by individuals with mental disorders in South Africa or other developing countries. Chapter 3 addresses this gap by answering the following question:

To what extent do patients suffering from a mental illness in South Africa consult traditional healers for their emotional and mental health care concerns?

Since South Africa, like many African countries and indeed, most developed societies, has a pluralistic system of mental health care, other health care alternatives are accessible. These may include: self-treatment, traditional family and community knoweldge and various other non-conventional therapeutic systems (Crawford & Lipsedge, 2004). According to Swartz (1998), one of the challenges in understanding pathways to mental health care, is the common notion that formal psychiatric services are the last resort in the search for effective treatment. The author notes that a more accurate model depicts people moving back and forth between different types of healers in a much less predictable way than previously conceived.

Several studies have shown that traditional healers may play an important role in addressing the mental health care needs in South Africa by offering culturally appropriate treatment (Freeman et al., 1994; Mbanga et al., 2002; Nattrass, 2005). In many traditional African belief systems, mental health problems are perceived as due to ancestors or by bewitchment and traditional healers and religious advisors are viewed as having expertise in these areas (Mbanga et al., 2002). This topic is often explored in the field of cross-cultural psychiatry, which will now be discussed in more detail.

2.4 Cross-Cultural Psychiatry and South Africa

This section will begin by describing the approaches to investigating culture and mental health, the universalistic and relativistic approaches, followed by an introduction to explanatory models. Specifically, it will discuss how earlier literature distinguished Western and traditional views of illness, and how this view is problematic and difficult to defend. Furthermore, evidence of the use of multiple explanatory models to describe or explain mental illness will be highlighted and a description of how mental illness may be conceptualized by many South Africans will be discussed. In this section, due to a lack of better options, the terms 'traditional' and 'Western' are frequently used. With the employment of these terms, it is acknowledged that they are awkward and rather unhelpful in describing the ideology, beliefs and practices they represent

2.4.1 Approaches to Investigating Cross Cultural Psychiatry

In cross-cultural psychiatric research there are predominantly two schools of thought, the universalistic and relativistic positions, which view and operationalize the importance of culture in different ways (Kleinman & Good, 1985). Firstly, the universalistic or etic approach advocates the universality of medical and mental illness. It assumes that mental illness is similar throughout the world and psychiatric categories and their measuring instruments and models of health care that are designed in the West are relevant globally (Kleinman & Good, 1985). This view presently dominates the bio-medical models of mental illness, and although does not deny that there are cross-cultural differences; they are regarded as less important than the extensive similarities. The categorising and labelling of conditions is part of the universalistic approach and is necessary for cross-cultural evaluation as it utilises standard units and categories (Kleinman, 1980). However, to appraise certain phenomena from within a culture with a view to recognising its meaning and relationship with other intra-cultural elements can be seen as a relativist or 'emic' position (Good, 1992). This entails assessment using values and meanings intrinsic to a particular group with the belief that measurement tools developed in particular situations are ill-equipped to determine the differing ways in which emotional distress is expressed in different contexts.

Both these perspectives have their strengths and limitations (Kirmayer, 1989; Kleinman, 1980). While etic approaches have distinct advantages and are essential for cross-cultural comparison, they fail to recognize how the socio-cultural context shapes the experience, meaning, expression and definition of illness (Kirmayer, 1984; Kleinman, 1988a,1998b;

Scheper-Hughes, 1987; Waxler, 1977). On the other hand, the emic approach is essential for an intuitive and empathic understanding of a culture and can be a valuable source of inspiration of universalistic hypotheses. However, since emic studies usually rely on small samples and often lack standardized research methods, the findings are based on the interpretations of the individual researcher (Kirmayer, 1984; Lutz, 1985). This makes it difficult to facilitate large scale comparisons. Therefore, etic studies may lack cultural validity, while emic studies may lack comparability (Kleinman, 1988). Today, there appears to be a general consensus that an integration of these two approaches is required in cross-cultural psychiatry (Kleinman, 1987; Littlewood, 1990; Patel, 2001; Stein, 1993).

A great deal of literature in cross-cultural psychiatry focuses on culture bound syndromes, which can be approached from an etic or emic perspective. A culture bound syndrome is a combination of psychiatric and somatic symptoms that appear to fall outside conventional Western psychiatric diagnostic categories (Niehaus et al., 2004). They are indigenously thought of as illnesses or afflictions, have local names and are limited to specific "cultural areas". Even the authors of the DSM-IV (1994) who are bound by the limitations of an etic approach are attempting to be integrative by including the term culture-bound syndrome in the fourth version of the Diagnostic and Statistical Manual of Mental disorders (APA, 1994).

A number of culture-bound syndromes have been identified in South Africa (Edwards et al., 1983; Edwards, 1984; Ngubane, 1977; Schweitzer, 1977). A study conducted by Ensink and Robertson (1999) attempted to classify culture-bound syndromes according to Western criteria by assessing categories of distress according to traditional healers among children and adolescents. Initially, ten healers were interviewed to identify categories of distress and dysfunction. Thereafter, a further sixteen were interviewed to elicit further information on these categories. All of the categories were recognized and had specific indigenous names. These included: *ukuthwasa* (calling to be a healer); *amafufunyane* (possession by evil spirits); *ukuphambana* (madness); *isinyama esikolweni* (bewitchment at school); and *ukuphaphazela* (episode of fearfulness). Although *ukuthwasa* is not necessarily believed to be a disorder or illness, it can progress to another illness such as *amafufunyane* or *ukuphambana* if the calling to be a healer is not fulfilled. Results indicated that *Isinyama esikolweni* (bewitchment at school) and *ukuphaphazela* (episode of fearfulness) can be considered as cultural variations of DSM IV disorders. *Isinyama esikolweni* meets the DSM- IV criteria for conversion disorder with sensory deficit (similar to brain fag syndrome), and *ukuphaphazela* is similar to sleep terror disorder. However, *ukuthwasa* (calling to be a healer), *amafufunyane* (possession by

evil spirits) and *ukuphambana* (madness), have been identified in both adults and children, and can be characterized as culture bound syndromes as they do not correspond to specific DSM-IV disorders. This study is an example of research that utilized both emic and etic methods in an investigation of mental illness.

There are a number of other research studies that that have shown an integration of both etic and emic approaches in cross-cultural psychiatry. One example is work on the cross-cultural adaptation of psychiatric research instruments (Drennan, Levett, & Swartz, 1991; Patel et al., 1997; Smit, van den Berg, Bekker, Seedat, & Stein, 2006). The emic approach penetrates what is primarily considered to be an etic research activity (Smit et al., 2006). Another example focuses on patients who according to the Western categories of the DSM-IV are mentally ill. Explanatory models of how patients understand their problems, its nature, origins, consequences and treatment are elicited (Kleinman, 1980; Patel et al., 1995b). Additionally, research examining the role of culture in psychiatric disorders can be elicited by investigating the explanatory models of community members, including traditional healers (Okello, 2006; Patel et al., 1995b; Shanker, Saravanan, & Jacob, 2006). The next section explores this in more detail.

2.4.2 Explanatory Models of Mental Illness

> *'The explanatory models' framework provides the clinician with an expeditious practical method to assess the more accessible meanings that hold clear-cut importance for care. The picture so constructed is doubtless crude, incomplete, biased. But it is usually 'good enough' for the purpose at hand: namely, to alert the clinician to the psychosocial setting of the sickness and to make available to him an appreciation of at least some of the dominant meanings expressed and reproduced by the illness experience".*
>
> (Arthur Kleinman, 1981, p.374)

Eliciting patient explanatory models is a key element when examining the role of culture on psychiatric disorders, predominantly in clinical research (Patel, 2000). The explanatory model framework is based on the notion that reality is socially constructed. An explanatory model (EM) is defined by Kleinman (1980) to denote the 'notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process'. These models are linked to particular categories of illness, and reveal labels and cultural idioms for expressing

the experience of illness (Kleinman, 1988a). Therefore, the idea of explanatory models is the acknowledgment that each patient may hold their own concepts and categories of illness and these can often differ from those of clinicians. In order to obtain a complete picture of a patient's explanatory model you would need to elicit how ill health is perceived and interpreted and how decisions are made about the most appropriate treatment (Bhui & Bhugra, 2006).

The Explanatory Model Interview (EMI) (Weiss, 1997) and the Short Explanatory Model Interview (SEMI) (Lloyd, Jacob, Patel, Bhugra, & Mann, 1998) are the tools commonly used to elicit explanatory models of mental illness. Although the EMI is time consuming and rather expensive to use in large scale surveys, it has the advantage of incorporating process rules and a specific method of presenting data. On the other hand, the SEMI takes about 20-30 minutes to complete. Although there is not an agreed system of managing and analysing the data, it can be used to identify causal and other health beliefs, which can then be categorised for use in large-scale survey work. It allows discussion of the patient's problems, as well as exploring different ways of explaining distress by presenting case vignettes (Bhui & Bhugra, 2002)

The Short Explanatory Model interview (SEMI) is semi-structured and is divided into five sections to cover the subject's background, nature of the presentation problem, help seeking behaviour, interaction with physician/healer, and beliefs related to mental illness (Lloyd et al., 1998). The section on illness beliefs consists of three vignettes of common mental disorders. The presentation of the vignettes is followed by open-ended questions to elicit the individual's attitudes concerning: 1) the clinical problem, perceived causes, consequences, and severity, 2) its effects on body, emotion, social network, home-life and on work, and 3) possible course of action, help-seeking behaviour and the role of the physician/healers. Each section is designed to stand alone allowing for flexibility in the ordering of the questions (Lloyd et al., 1998).

The concept behind explanatory models was developed in a clinical setting. It is recommended that health care practitioners assess patient's explanatory models to aid in the assessment, diagnosis and therapeutic relationships of the patient (Bhui, Rudell, & Priebe, 2006). Through exploration of patients' explanatory models of illness, (why me, why now, what is wrong and who can intervene?) the clinician can achieve a better understanding of the subjective experience of illness and so promote collaboration and improve clinical outcome and patients satisfaction (Callan & Littlewood, 1998; McCabe & Priebe, 2004).

There is some evidence that health beliefs may indirectly influence clinical outcome (Callan & Littlewood, 1998; McCabe & Priebe, 2002). For example, Callan and Littlewood (1988) interviewed 21 white British and 63 ethnic minority patients admitted to an acute psychiatric unit in central London. Information on patients' explanatory models, treatment preference, overall satisfaction and their opinions on psychiatric in-patient care were elicited. Results indicated that satisfaction is most likely when there is an agreement between the patients' and doctors' explanatory model. However, ethnic status was not related to a concordance of explanatory models or to patients' overall satisfaction. More recently, a study conducted in the UK interviewed 109 patients from four distinct cultural backgrounds who met DSM–IV criteria for a diagnosis of schizophrenia. A number of constructs were assessed including explanatory models, treatment compliance, treatment satisfaction, and therapeutic relationships. Results suggested that biological explanatory models (compared to social & supernatural) were associated with superior therapeutic relationships and overall satisfaction with services. There was no relationship between explanatory models and adherence to treatment (McCabe & Priebe, 2002). However, due to the small sample sizes in these studies on explanatory models and the low statistical power, the results are not conclusive and difficult to generalize to other populations. According to Bhui and Bhugra (2002), the impact of specific explanatory models on satisfaction with consultations, adherence to treatments, and clinical outcomes has not been systematically assessed.

2.4.3 Earlier Literature on Traditional Belief Systems

Earlier literature in South Africa describing traditional beliefs laid the groundwork for subsequent investigations into explanatory models. There has been an unfortunate trend in the research involving black South African psychiatric patients to view the "black experience" as being homogenous throughout the continent, despite differences in class, social position, geography, language, religion and culture (Swartz, 1996). Similar to his ethnopsychiatric colleagues such as Carothers and Sachs (McCulloch, 1995), Laubscher (1937) classified disease and healing in South Africa by utilizing the term "African Personality". This perception of classification categorized behaviour using mutually exclusive polarities, such as natural/unnatural and rational/irrational, with the "African Personality" being compared to the more rational and intelligent Europeans. Although less obvious, these distinctions have laid the foundation for a number of subsequent researchers (Bührmann, 1984; Cheetham & Cheetham, 1976; Hammonde-Tooke, 1989; Ngubane, 1977).

To begin with, one of the most well published researchers in this field is Vera Bürhmann who immersed herself into the complexities of South African culture by conducting extensive research into Xhosa traditional healing methods during the 1970's and l980's, using Jungian concepts. This resulted in numerous publications (Bührmann, 1981, 1987; Bührmann & Gqomfa, 1981, 1982a, 1982b) and her seminal book "Living in Two Worlds" published in 1984. Bürmann viewed traditional healers as living holistically and in harmony with nature. Although she made an extremely valuable contribution to the literature with her account of traditional healer practices, the Jungian concepts presented in her work have not been expanded on by many researchers in this area (Swartz, 1986). Using the Jungian concepts, Bührmann believes that the Xhosa people she studied throughout her career were closer to their unconscious than the more conscious Westerners, so it has been argued that she maintained that Blacks are less rational than whites (Swartz, 1986).

Ngubane (1977), who worked extensively with rural Nyuswa valley Zulu people in South Africa and provided a detailed ethnography, made a clear distinction between natural (*umkuhlane*) and supernatural (*ukufa kwabantu*) causes of illness. This distinction is similar to that made by Murdock, Wilson, and Frederick (1980) who developed a comprehensive classification of theories of illness in developing countries. Natural causation refers to diseases that have a specific nature, implying a recognized cause and a regular and predictable course. Therefore, afflictions such as coughs, colds, slight fever, stomach ache and headache are generally regarded as 'natural' since they occur from time to time as part of normal life, are usually of a fleeting nature, and resolve completely. These illnesses can respond to either traditional or modern medicines. On the other hand, 'Supernatural' applies to culture bound illnesses that are perceived to be inexplicable by natural laws. The Zulu term "*ukufa kwabantu*" literally refers to disorder of human beings, but Ngubane (1977) specifically refers to it as a "disease of the African peoples". Ngubane (1977) expresses her beliefs which focus on the mysterious and exotic in the following quotation:

> *The name is used mainly because of the philosophy of causality is based on African culture: this means not that the disease, or rather their symptoms, are seen as associated with African peoples only, but that their interpretation is bound up with African ways of viewing health and disease. (p. 24)*

Hammonde-Tooke (1989) published his works in a book entitled "Rituals and Medicines". The author makes a clear distinction between the more "scientific" worldview and the African

"pre-scientific" worldview. He further describes the traditional view of illness as falling broadly under four different categories including: Supreme Being, Ancestors, Witchcraft and Pollution Beliefs (Hammond-Tooke, 1989). It is believed that all of these have immediate relevance to the problems of health, illness, well-being, and the belief in life after death.

(1) Supreme Being- God created the world. All creation is the action of God, who continues to care for all aspects of existence;
(2) Ancestors-In the African tradition the ancestors not only play a pivotal role in the causation of illness, but in the healing and therapeutic process as well. An individual is connected to his or her clan through the ancestors who are responsible for protecting their living relatives. Although ancestors are invisible to the human eye, similar to the living they reside in the home and often have a preferred part of the house they like to inhabit. This could include such places as the living room, the rafters or next to the cattle byre. It is generally the last one or two generations that are worshiped;
(3) Witchcraft- Witchcraft is the 'evil' faction of the Supreme Being and the ancestors, and various methods can be used to inflict harm on unsuspecting enemies. As in other parts of the world, the women are called witches and the men sorcerers, and these people can be anyone - roommate, teacher, or bride. This person is thought to be secretly plotting the destruction of their enemy;
(4) Pollution Beliefs - Some forms of illness are believed to be caused by a state of impurity in the person. Typical examples of these are widows, women who have had miscarriages, people who have handled corpses or even people who have completed a long journey.

Cheetham and Cheetham (1976) investigated how the rural Xhosa people in South Africa view mental illness. Although the participants recognized a variety of types of mental illnesses, only a few were believed to be cause by abnormalities in the brain. The remainder (almost all of them) were attributed to external factors including: failure to conduct appropriate sacrifices and rituals to appease the ancestors; Ancestor displeasure due to non-observance of taboos, bewitchment; sorcerers sending evil spirits; and excessive worry and concern over particular situations that were not shared with the community. The authors go on to argue that in the Xhosa population they investigated "abstract concepts are limited and ego defence mechanisms include projection, displacement and rationalization, but cognitive disturbances are not as important". Essentially the authors are arguing that constructs such as intelligence or intellect are either not available or important to this population (Swartz, 1986).

Edwards et al. (1983) found a significant relationship between the psychiatric diagnosis of the patient and the particular theory of illness provided. One hundred files of Black South African psychiatric patients at a hospital in Durban treated over the year 1980 who construed the etiology of their problems in traditional terms were investigated. The traditional diagnostic category of each patient was classified according to the exotic and mysterious systems of Murdock et al. (1980). This classification system reiterated the basic distinction between theories of natural and supernatural causation described previously. This system included *magical* theories of illnesses which resulted from witchcraft or sorcery caused by an enemy. *Animistic* theories are used when an individual fails to perform rituals involving their ancestors. *Mystical* theories consisted of ecological health hazards. Results indicated that the majority of Africans in both urban and rural areas still hold predominantly traditional, or a combination of traditional beliefs regarding mental illness. Furthermore, the more severe disorders (psychoses, mental retardation, and epilepsy) were more likely to be ascribed to the animistic theories, while less severe disorders were attributed to magical theories, as these causes are culturally acceptable for this population.

Looking at this earlier literature, it appears that Western and traditional views of illness were described as having mutually exclusive and distinct explanatory models of disease (Bührmann, 1984; Cheetham & Cheetham, 1976; Hammonde-Tooke, 1989; Ngubane, 1977). This simplistic view described the Western concept of disease as a chemical, physiological or anatomical variation that manifests itself in ill-health. Therefore, the body is mechanistic in nature; a machine, prone to malfunctions, requiring tune-ups or occasional part replacement (Bruce, 2002). On the other hand, the traditional concept of illness represents personal, interpersonal, and cultural forces that are governed by family, social, and cultural factors (Burnham, 1984; Cheetham & Rzadkowolski, 1980; Hammond-Tooke, 1975, 1989).

It is not surprising that the explanatory models of Western and traditional medicine referred to above (Buhrmann, 1984; Cheetham & Cheetham, 1976; Hammonde-Tooke, 1989; Ngubane, 1977) have been criticized for reinforcing overt stereotypes and for romanticizing exotic accounts of African culture (Swartz, 1985; Swartz & Foster, 1984). During apartheid, the illogical aspects of indigenous healing were often emphasized. It was believed that Africans would ‘naturally’ prefer consulting traditional healers than the more scientifically–based Western medicine (Swartz, 1985). This claim assumes that African people had a choice of health care practitioners, when in reality this was rarely the case due to the lack of access to Western health practitioners in many parts of the country. However, today there are more

health care options available to South Africans than in the past, making personal preference one of the primary drivers for consulting traditional healers.

Recent literature in South Africa provides evidence of a more fluid and nuanced understanding of culture (Ensink & Robertson, 1999; Lund & Swartz, 1998; Niehaus et al., 2004). Ensink and Robertson (1999) interviewed 62 African patients following their first hospital admission for a serious mental illness. They reported that traditional healers had been consulted by 61% of the patients during the previous 12 months. Of the 32 patients who described their illness or problem using indigenous names, 25 of them used a combination of Western and indigenous services. They reported that combinations of indigenous, psychosocial and religious factors generally caused the illness or problem. In total, 45 (80%) respondents regarded psychosocial causes as underlying the problem, 35 (63%) indigenous causes, 23 (46%) religious causes, three (5%) fate and four (7%) physical causes. Only eight saw indigenous causes alone as underlying their illness.

Similarly, Lund and Swartz (1998) interviewed 10 schizophrenic patients in Cape Town, South Africa in an effort to understand the patient's experience of their condition. Results indicated that even when respondents gave a spiritual or supernatural cause for their illness, psychiatric medication was reported to be the most preferred method of treatment. Furthermore, the term *amafufunyana* may function as an explanatory term, and not as a single diagnostic category, which was often reported in the earlier literature on the syndrome (Ngubane, 1977). Niehaus et al. (2004) examined the extent traditional healers used the terms *amafufunyana* and *ukuthwasa* as cultural explanatory models by 247 Xhosa patients diagnosed with schizophrenia. Results indicate that not all individuals with *ukuthwasa* and *amafufunyana* suffer from schizophrenia, but these terms may be used as explanatory models in a subset of schizophrenia sufferers.

2.4.4 Vignettes to Investigate Explanatory Models of Mental Illness

Most of the research investigating explanatory models of non-psychotic mental disorders has been conducted on mentally ill patients, using a modified version of either the Explanatory Model Interview Catalogue (EMIC) or the Short Explanatory Model Interview (SEMI) (Aidooi & Harpham, 2001; Ngoma et al., 2003; Okello, 2006; Patel et al., 1995a). For example, a study investigating explanatory models of non-psychotic disorders was conducted in Zambia with 139 women who met the criteria for a mental illness (according to the SRQ-20) and 10 health professionals who provide services to these women (Aidooi & Harpham,

2001). Participants' explanatory models were elicited using a modified version of the interview developed by Kleinman (1980). Results indicated that the women considered their distressing experiences to be life problems and only a minority considered their problems to be caused by supernatural phenomena. Causes such as poverty, lack of education and economic opportunities, low quality of relationships and unhappy marriages were reported. According to this group of women, a mental illness implies madness. On the other hand, the terms used by mental health professionals to describe a mental illness were 'stress' and 'depression'

Similarly, Patel et al., (1995a) interviewed 110 subjects selected from the clients of general nurses and traditional healers in Harare, Zimbabwe. The participants were interviewed using the Explanatory Model Interview and the Revised Clinical Interview Schedule. Results indicated that spiritual causes (e.g bewitchment) were mentioned by 45.5% of the sample. Other reported causes were specific somatic diseases (17.3%), socio-economic causes (19.2%), psychological causes (18.2%), and marital causes (19%). The patients were also asked about the role of eight factors in the aetiology of their illness. Thinking too much (*kufungisisa*) was seen as a possible cause by over 80% in both groups. The authors conclude that *kufungisisa*, seemed to be the Shona term closest to the Western concept of neurotic illness.

Furthermore, in order to elicit the illness beliefs of the general public and various community workers, including traditional healers, case vignetess of non-psychotic disorders are often used (Alem, Jacobsson, Araya, Kebede, & Kullgren, 1999; Muga & Jenkins, 2008; Okello, 2006; Patel et al., 1995b). For example, Patel et al. (1995b) conducted nine focus group discussions consisting of 76 care workers (30 community workers, 22 traditional healers, 15 relatives of patients and 9 psychiatric nurses) to elicit information on concepts of mental illness. Results indicated that participants were able to identify a mentally ill patient by their behaviours such as wandering away from home, eating or smearing faeces, laughing at inappropriate times, impaired self-care (such as not washing), or eating dirty food. Three case vignettes describing typical cases of non-psychotic disorders in primary care settings were presented to the care workers including: (1) a depressed woman, (2) a man with agoraphobia and panic attacks, and (3) and a woman with medically unexplained somatic symptoms. Results indicated that although the description of the patient was recognized by all care providers, most suggested that the descriptions provided did not reflect an illness, but psychological difficulties resulting from a number of external factors, such as poverty,

alcoholism, or poor marital relations. Therefore, more probable causes of depression were social, spiritual or "thinking too much". The participants in the study rarely regarded non-psychotic disorders as a medical problem and are almost never referred to them as mental illnesses.

According to the few studies conducted in Africa investigating the explanatory models (EMs) of mental illness, there appears to be a distinction between those of psychotic (e.g. schizophrenia and bipolar disorder) and non-psychotic disorders (Aidooi & Harpham, 2001; Patel et al, 1995a, 1995b). Patel (1996) hypothesizes that many Africans are unable to distinguish between non-psychotic and psychotic disorders, due mainly to an inability to identify non-psychotic disorders as being related to mental illness. Whether there is enough data to support this view is debatable since only a few studies have been conducted addressing this issue, none of them recent, and few outside Zimbabwe.

A few studies have been conducted in South Africa investigating traditional healers' perceptions of mental illness (Koen, Niehaus, Muller, & Laurent, 2003; Mufamadi, 2001; Mzimkulua & Simbayib, 2006; Robertson, 2006; Thorpe, 1992). For example, Mufamadi (2001) interviewed 8 traditional healers in Limpopo to investigate how they perceived mental illness, its causes and treatment methods. She found that a number of symptoms were associated with mental illness, including: aggression, talking incoherently, isolation, shouting loudly, confusion and strange behaviour. She also reported perceived causes such as heredity, witchcraft, sorcery, disregard of cultural norms and spirit possession. Similarly, Mzimkulua and Simbayi (2006) interviewed 4 Xhosa speaking traditional healers whose patients were being treated at the psychiatric hospital in order to determine how they manage psychosis. They reported that symptoms of psychosis included disorientation, auditory hallucinations, roaming aimlessly, lack or hygiene and living in the bush. Additionally, they found that there were multiple causes for mental illness including supernatural forces, substance abuse, psychosocial stress and genetic predisposition.

In summary, although a few studies have been conducted in South Africa investigating traditional healers' explanatory models of mental illness, none of them have specifically looked at non-psychotic disorders using vignettes from the Short Explanatory Model Interview. Chapter four will address this gap by answering the following question:

What are the explanatory models of non-psychotic mental disorders among South African traditional healers?

2.5 Traditional Healers in South Africa

This section will begin by describing the differences between the varying types of traditional healers: the diviner, the herbalist and the faith healer. A majority of the literature described in this section is not recent, and the references cited are predominantly 'emic' in nature, often anecdotal or the result of ethnographic or qualitative studies. Therefore, although the results are useful in obtaining information on traditional healer practices, it is difficult to generalize them to the South African traditional healer population. Finally, the cost of consulting a traditional healer for health problems will be addressed.

2.5.1 Types of Traditional Healers

Traditional healers are reported to be respected members of the community, functioning in multiple capacities. Their leadership and services are believed to play a major role in the arenas of health, governance, family disputes, marriage and divorce, sexuality and infertility, and guidance of children (Ngubane, 1977). They are knowledgeable of their culture norms, local language and traditions (Bürhmann, 1984). Furthermore, it is often assumed their advice is sought, believed and acted upon by community members (Nelms & Gorski, 2006).

The World Health Organization (1976) defines an African traditional healer as:

"competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious backgrounds as well as the `prevailing knowledge, attitudes and beliefs regarding physical, mental and social well-being and the causation of disease and disability in the community".

Similar to Western medicine, traditional healers are heterogeneous with a range of different types being identified in the literature. There are broadly three types of traditional healers: the Diviners, the Herbalists and the Faith healers (Edwards, 1986; Freeman & Motsei, 1992). Diviners (predominantly female) are believed to be specialists in divination within the supernatural context, giving them the ability to divine the cause of illness and misfortune (Ngubane, 1977). The herbalist (predominantly male) specializes in the production of herbal medicines, while faith healers integrate Christian ritual and traditional practices, and belong to one of the Independent African churches (Edwards et al., 1983). There is, however, some

debate over whether or not faith healers should be considered a 'traditional healer' since their healing practices combine Western and traditional approaches (Edwards et al., 1983). Although it is acknowledged that there are other types of traditional healers practicing in South Africa (e.g. traditional birth attendants & surgeons), their practices will not be discussed as their relevance to mental health care is minimal.

Earlier literature reported distinct differences between the practices of diviners, herbalists and faith healers (Edwards, 1986; Freeman & Motsei, 1992). While these broad distinctions seem to be generally valid across different African language groups (Rudnick, 2001), some authors describe healers who integrate more than one type of healing method into their every day practice (Freeman & Motsei, 1992; Last & Chuvundaka, 1986). For example, Chavundaka (1985) described diviner-herbalists who are able to diagnose a patient using the divining bones, and treat the diagnosed illness with their own herbal preparations. Furthermore, Freeman and Motsei (1992) reported grades within each category ranging from novices to specialists and consultants. Details of the training methods and practices of diviners, herbalists and faith healers will now be discussed in more detail.

A. *Diviner (Sangoma)*

Although diviners are known by different names in the various South Africa cultures (e.g. amagqira in Xhosa, *ngaka* in Northern Sotho, *selaoli* in Southern Sotho and *mungome* in Venda and Tsonga), they are generally referred to as *sangomas* (from the Zulu word izangoma). The literature suggests that *sangomas* are usually women (90%) who have an extensive knowledge of medicine. However, it is the practice of divination within the supernatural context that sets them apart from the other types of healers (Freeman & Motsei, 1992; Ngubane, 1977).

In his extensive account of traditional medicine in Zimbabwe, Chavadunka (1994) describes in detail the methods used by *sangomas* to perform divination. To begin with, *sangomas* often use bones, seashells and other objects as a tool to communicate with their ancestral spirits. These tools, often referred to as "bones", are carefully selected and can include any item that the *sangoma* feels has a particular significance to them and will ultimately aid in the communication with their ancestors. The *sangoma* throws the bones and depending on the specific way the 'bones' land, the ancestral spirits send messages to the healer. In other instances, the ancestors respond to the *sangomas* questions directly, by whistling out words from the rafters. A number of examples are provided by Chavadunka (1994), of healers who

can diagnose and predict the patient's reason for consultation, and ultimately the social cause of their illness, without the patient having to indulge any information. Once a particular spirit has been identified as the cause of an illness or misfortune, the *sangoma* advises the patients on the procedure necessary to release the spirit. Herbal treatment may also be prescribed in order cure the physical damage already experienced by the patient.

Therefore, *sangomas* not only diagnose the illness, but also specialize in establishing causality for events that are distressing to their patient or even a particular community. Gumede (1990) notes that one of the main reasons for consulting a *sangoma* is to determine the 'ultimate cause' of an illness in terms of the African concept. For example, a diviner may be consulted to determine "why the cows are barren, why the fields are not producing plenty of crops, why the young bride is not having a baby after two years of married life, why the child is ill, why ill-luck dogs the family, why the cow died- In fact why anything has gone wrong" (Gumede, 1990, pg, 69).

There are a number of differences between the training of Western practitioners and that of the *sangomas*. The training of health practitioners in the Western world is reported to be formal and academic, with the knowledge and skills provided to the trainees being based on sound educational principles. Furthermore, there are often high standards applied to the selection and qualifications of those who complete the training (Bruce, 2002). On the other hand, according to many authors providing ethnographic accounts of the initiation process of *sangomas*, a person does not choose to become a *sangoma* (Bürhmann, 1977; Ngubane, 1977; Schweitzer, 1977). Instead, they are 'called by their ancestors' to become a healer, and often acquire their healing methods as skills from an unknown spirit or a deceased family member (Bürhmann, 1977; Hammonde-Tooke, 1989; Mufamadi & Sodi, 1999; Ngubane, 1977; Schweitzer, 1977)

According to Hammonde-Tooke (1988, 1989), *sangomas* are called to the healing profession by their ancestors through the sending of an illness, referred to as thwasa, or *intwaso,* a term derived from the verb *ukuthwasa. Intwaso* is characterised by a number of negative experiences which are believed to be sent to them by their ancestors. These can include bad dreams, extreme anxiety and madness. In order to be cured of this *intwaso* illness, the inflicted individual must become an initiate, thereby accepting the calling to become a healer. Essentially, going through the training process to become a *sangoma* is the treatment for this specific illness. Those who become healers gain entry into a mutually supportive healing

network, have access to improved social status in the community and an opportunity for financial gain (Ensink & Robertson, 1999).

This "illness" could be the reason why *'thwasa'* is often regarded as a culture bound syndrome in the literature (Schweitzer, 1977; Ngubane, 1977; Edwards, 1983). There is some literature suggesting *thwasa* and ultimately the mental health status of *sangomas* is associated with psychotic illness, such as schizophrenia (Hammone-Tooke, 1989; Laubscher, 1937). For example, Hammond-Tooke (1989) describes the calling to become a traditional healer as severe, dramatic, and appears similar in behaviour to patients with schizophrenia in Western medicine and that only an experienced diviner is able to accurately diagnose. However, this author's conclusion may be overly romantic and perhaps there is a dramatic difference between a serious psychotic illness such as schizophrenia and a normal trance of the healer (Buhrmann, 1977). Especially since *sangomas* appear to be well functioning members of the community (Bührmann, 1977; Schweitzer, 1977). However, as Schweitzer (1977) points out, not all *'thwasa'* graduate and become a full-fledged *sangoma.* The health of many of the initiates deteriorate, some being re-diagnosed as *Phambana* (crazy/mad).

Gumede (1990) notes that once a ritual ceremony is performed where the individual honours and accepts the spirit, the initiate may then leave their home to live with and be tutored by a reputable master *sangoma.* This apprenticeship does not have a set time frame since the duration of training depends on the skill of the trainee and the co-operation of the ancestors. During apprenticeship, the student is required to complete and pass a number of tests, which can take place over a period of years (Chavadunka, 1994). Once the tutor is satisfied with the performance and success of the student, graduation preparations begin (Gumede, 1990).

Bührmann (1987) describes the graduation ceremony of *sangomas* in great detail. The initiation ceremony is described as a celebration, together with a solemn prayer that the ancestral spirits may guard and guide the new mediator between the living and the spirit world. A sacrificial beast (in most cases a goat) is slaughtered, and an essential part of the ceremony is the blood. The spilling of this blood is meant to seal the bond between the ancestors and the *sangoma*. Once the goat has been skinned and opened up, the diviner takes out the gall bladder and sprinkles the student from head to toe with the gall.

The literature suggests that it does cost money to be trained by a traditional healer, although this rate is not fixed and different healers charge different rates (Bürhmann, 1977; Ngubane,

1977). However, Green and Makhubu (1984) estimated three years of traditional healer training would cost approximately US$200, in addition to a number cows or goats. Few papers have followed this up, but they are likely to be much higher.

B. Inyanga (Herbalists)

According to Louw and Pretorius (1995), *inyangas or herbalists* (predominantly male) make use of therapeutic procedures and are recognized as the traditional doctor in the community. Herbalists specialize in the production of herbal medicine as they possess an extensive knowledge of natural treatments, curative herbs and medicinal mixtures of animal origin. Among their remedies are mixtures of leaves, roots, minerals and animal parts (can be skins or fats). Staugard (1985), describes herbalists specializing in the retail or wholesale of herbal drugs. The herbalist is seen selling his preparations from a small shop or stand at the market or may travel around to distribute his medicines to clients. According to Louw and Pretorius (1995), the medicines brewed by herbalists can be rather complex, making training in this area arduous.

According to Chuvunduka (1994), herbalists unlike diviners, do not have to be called to the profession, even though the medicines used are considered to have magical qualities. The training to become a herbalist is not standardized; instead it is principally based on hands-on experience. The novice is apprenticed to a practising herbalist of repute for a number of years. The period of apprenticeship varies in standard and format from one area to another. The apprentices' job is to act as a messenger, a herb gatherer, and a general helper to his master. The novice accompanies his masters on excursions as medicine-bearer, continually learning by observation and instruction. He is also taught how to select the most powerful specimens. Later he is sent to go and dig alone, but to bring his findings to the master for checking and approval. He then learns how to mix the various ingredients and prepare various mixtures. Furthermore, the novice assists the herbalists in the administration of medicines and is allowed to treat some patients according to the master's instructions. After a few more years, the student is introduced to the management of progressively more severe illnesses and problems. Only then is he given permission to treat patients on his own (Chuvunduka, 1994).

C. Umthandazi (Faith Healer)

The faith healer integrates Christian ritual and traditional practices, and belongs to one of the Independent African churches. Freeman (1992) notes that these healers can be traced back to the rise of the independent African church movement, which separated themselves from the Western, oriented missionary churches. Although this group of healers did not exist prior to the development of Western medicine, they have adopted a similar explanatory model of health and disease as other traditional healers, such as the belief in witchcraft and of the supernatural.

According to Abdool Karim et al. (1994), "faith healers believe their healing power comes directly from God, through ecstatic states or trance-contact with spirits, or sometimes a combination of both ancestral spirits and Christian Holy Spirit possession"(pg 7). Staugard (1985) further describes faith healing as a calling from God, and treatment often includes prayer, although sometimes prayer is used in combination with holy water, candles, ashes and other aids to prayer. The author further describes how faith healers diagnose patients, which included simple procedures of asking the patient to "open the bible", following which the practitioner is able to "read the diagnosis" from the respective pages. In other cases, the healer himself may open the bible in front of the client or make the diagnosis by laying his hands on the holy book.

Peltzer (1999) interviewed 80 faith healers in the Northern Province of South Africa in order to investigate their specific areas of specialization, their case-load, and the nosology and etiology of the disorders they treat. According to the author, healing in the independent church can occur in three very different ways: healing during church services, healing by immersion, and healing through consultation with a prophet. The prophet healers in the study reported to have the ability to predict, heal, and divine. These powers were given to them by god himself. Results indicated that the most commonly treated illnesses and problems reported by the healers were grouped into the following diseases/problems: witchcraft and sorcery related disorders, substance abuse and chronic diseases, children's diseases and mental disorders and physical disorders.

A study conducted by Thorpe (1992) in South Africa interviewed 6 Zionist Prophets on a number of occasions, in order to investigate a multitude of aspects of their practices. Diagnosis of patients often took place in the evening in the kitchen of the senior prophet. However, the leader of this particular church was interviewed concerning 16 of the most frequently treated psychiatric-type illness which were then categorized into labels that

resembled: (1) Psychotic-like illnesses (2) Neurotic-like illnesses (3) The epilepsies (4) Somatic type illnesses. These healers described curing these illnesses through healing ceremonies and prayer. The treatment sessions lasted approximately 3 hours and were held every evening, except for Saturdays. The prophets in this study described using a variety of diagnostic tools to find out what their patient is suffering from. These included: a)sensation transference – where the feeling/symptoms that a patient is experiencing are transferred to the prophet. (b) various forms of visions seen by the prophets. c) the interpretation of the patients and prophet's dream, and d) precognition- where the prophet already knows what is wrong with the patient prior to any consultation. According to the author, the training of faith healers is similar to that of the *sangomas,* since the "trainee" prophets must undergo strict training procedures, under the supervision of a senior prophet. Over time, a number of diagnostic tools (described above) are developed and honed by the aspiring faith healers.

The literature suggests that faith healers are becoming increasingly popular in Africa, and there is some research indicating that religious leaders are frequently sought for mental health problem. Roux (1977) notes the Zionist priest or prophets are replacing the role of the traditional healer in South Africa. However, since little research has been conducted with this group of healers, their contribution to mental health and their role in treating patients in South Africa remains unknown (Teuton et al., 2007).

2.5.2 Costs of Consultation

The cost of traditional medical care varies with the nature of treatment, the type and severity of ailment and the relative wealth of the client. In general, the fee schedule to consult a traditional healer is neither fixed nor standardized. The fee charged varies from region to region, between healers, according to the type of illness and the nature of the treatment (Abdool Karim et al., 1994). Chuvunduka (1994) states that many urban healers nowadays receive their fee for herbs that they recommend to their clients straightaway instead of waiting to collect their dues after a cure has been effected and the patients family is satisfied. However, in rural areas, most traditional healers continue the normal practice of receiving a small retainer fee that is paid initially, followed by the remainder of the payment once treatment is complete and the patient is healed.

Fees to consult a traditional healer can be high (Case, Menendez, & Ardington, 2005; Ensink & Robertson, 1999; Green & Makhubu, 1984). For example, in a study assessing satisfaction

with the psychiatric services of 62 patients in Cape Town, a majority reported that aside from costly transport costs, a majority of participants reported that treatment at psychiatric facilities was free of charge. However, results suggested that for a course of treatment diviners charged on average R1335, herbalists charged R434, and faith healers R155. In addition, a recent study conducted in Kwa-Zulu Natal examined patterns of health-seeking behaviour prior to the death of 1282 individuals. Information on the health care choices and expenditures of these individuals, who died between January 2003 and July 2004, were provided by the primary care giver. Fees for consulting a traditional healer ranged from 0-R4000, with an average of R433 (Case et al., 2005). However, unlike other parts of the world such as China, where alternative medicine is integrated into mainstream health care delivery and practitioners receive compensation from the government for their practices, traditional healers in South Africa are not supported financially by the state, as physicians are.

Despite not being financially supported, traditional healers utilize a variety of healing techniques in order to cure their patients from both disease and misfortune. The following section will focus on the practices of traditional healers.

2.6 Traditional Medicine in South Africa

According to Nyika (2007), African traditional medicine can be divided into two main branches. The first branch of African traditional medicine involves 'herbalism', the use of herbal plants that produce and contain a variety of chemical compounds that act upon the body to treat disease or promote health. The second branch is based on occult or supernatural powers usually performed by a *sangoma,* who acts as a spiritual medium in order for the ancestral spirits to diagnose and prescribe appropriate treatment. Although simple surgical procedures do not fit nicely into either of these two categories, they are reported to be frequently used by traditional healers. This section will describe these branches of traditional medicine (including surgical procedures), in addition to presenting the available research that supports and opposes the effectiveness of these practices. Lastly, the existing research available on the treatment practices of traditional healers specifically for mentally ill patients will be presented.

2.6.1 Herbalism

Although many traditional healers undergo the arduous and time consuming task of collecting their own herbs, Amayeza stores (African chemists) may be a valuable resource for them (Cocks & Dold, 2000; Cocks & Moller, 2002). Cocks & Dold (2000) examined the use of Amayeza stores over a period of eight months through questionnaires, in-depth interviews, participant observation and empirical recordings. The purpose of the 120 questionnaires distributed to the customers was to obtain demographic information pertaining to the medicines they purchased. These stores stocked much more than the traditional Xhosa medications, but also commercially manufactured medicines, and other medicines derived from Dutch, Indian, and Chinese cultures. Results indicated that the most popular category of medicine purchased by the consumers in this study was "Protection from Evil Spirits" (28%), "Preparation of Mixtures" (16%) and "Medicines for Rashes and Complexion Problems" (14%). In addition, 24% of the medicines purchased at the Amayeza stores were by traditional healers and faith healers. It was reported that it was much more cost-effective for the healers to purchase the herbal medicines in bulk then to collect the herbs themselves in the bush.

According to Ngubane (1977) the most frequently used therapeutic method by African traditional healers is herbal medication. The traditional healer relies heavily on the power of plants to heal. The herbalist or diviner administers *imuthi* or *imbiza* (medicines) that are usually of vegetable origin to treat diseases or ailments (Ngubane, 1977). One author notes that raw herbs are ground into powders to be taken with water, or infusions are made with barks or roots. Other *imuthi* are rubbed into incisions (*ukuchaza),* inhaled as smoke (*ukuqhumisa)* or chewed on (*ukuncinda)* (Gumede, 1990).

Since "herbalism" is a branch of traditional medicine based on phytochemical components of herbs that are known to have medicinal properties, it is not unreasonable to suggest that they may possess therapeutic benefits. For instance, artemisinin, which is derived from the plant *Artemesia annua* and the extract of *Cryptolepis sanguinolenta* has been scientifically tested and shown to be an effective treatment for malaria (Ansah & Gooderham, 2002). Furthermore, some of the most effective cancer drugs available are also plant derived such as Vincristine (from periwinkle), Etoposide (from mayapple) and Taxol (from the pacific yew tree) (Cragg & Newman, 2005). However, it appears that once a treatment has been accepted into mainstream medicine it ceases to be viewed as "alternative" or "traditional". The origin

of the effective treatment is quickly forgotten and the remaining alternative treatments continue to be viewed with suspicion, doubt and misunderstanding.

Although there is lack of studies available investigating the effectiveness of traditional herbal medicine using the "gold standard" double-blind, placebo-controlled trials, a number of prospective open-label studies have been conducted. Examples of studies investigating the effectiveness of herbal treatments for HIV and AIDS were discussed by participants attending an international Workshop on Traditional Medicine and HIV/AIDS in Uganda (as described in Bodeker, Carter, Burford, & Dvorak-Little, 2006). For example, in South Africa 200 terminally ill HIV patients were given a four-plant mixture, commonly prescribed by traditional healers, over a two year period. Results indicated in 31% of the participants that the mixture was effective in boosting CD4 counts by 99%, reducing viral loads by 79%. However this study remains unpublished in the peer review literature. Another study conducted in Senegal, assessed the effects of METRAFAIDS (a plant-based treatment) against HIV/AIDS. Three cohorts of 62 HIV positive patients participated in the study. Prior to treatment, CD4 counts and viral load were assessed and then re-assessed monthly during the course of the treatment. Physical examination and reported symptoms provided the basis for determining opportunistic infections. Patients were also monitored for fungal and bacterial infections (e.g. fever). Patients were treated for a period of 4 to 6 months. Results indicated that Metrafaids reduced the viral load (66%) and increased the CD4 count (73%) (a measure of a type of blood cell killed off by HIV) of a majority of the respondents. Furthermore, the weight of 85% of the respondents had increased (Ewurama, 2005).

Another promising study evaluating the effectiveness of herbal treatment for herpes zoster in people living with HIV/AIDS (PLWHAs) was conducted in Uganda. The first phase consisted of 52 patients who were enrolled and treated at three healers' clinics. These patients were compared to clinic patients who were treated using acyclovir and receiving ambulatory care (3 month follow up). The research design of Phase 2 was identical to Phase 1, but lasted longer (6 month follow up) using 154 traditional patients and 52 clinic patients. Although there was no significant differences between these two groups, results indicated that the traditional medicine group had less super-infection, showed less keloid formation and the pain due to herpes zoster reduced significantly faster in the group on the herbal medicine compared to those patients on acyclovir (Homsy et al., 2000). Although these findings are promising, the existing research on this is clearly inadequate since longitudinal observation studies are based on too small sample sizes; and few studies have used randomized, blinded, controlled trials.

Despite the "potential" of the herbal medication described above, herbs used by traditional healers are generally crude mixtures and often lack adequate information about safe dosages and potential harmful side effects. There is substantial evidence that the non-standard provision of traditional herbal medicine has many negative implications for patients. For example, cases of acute poisoning due to traditional medicines are not uncommon, and many of these have resulted in significant morbidity and mortality (Stewart et al., 1998). Mortality is estimated to be as high as 10 000 to 20 000 per annum. Stewart, Moar, Steenkamp, and Kokot (1999) analyzed the Johannesburg forensic database over five years (1991-1995) and found that traditional remedies, all of plant origin, were involved in 43% of poisoning cases.

Of course, Western medicine is not without its faults. Over the years, as science has become more technologically advanced, the general public has become concerned about the efficacy of new procedures and medicines. Randomized control trials assess the efficacy of a treatment and only treatments that have been found to be significantly effective are made available to the public. Furthermore, similar to traditional medicine, there are also problems with the provision of standard treatments for psychiatric disorder in the West. Lack of expertise, resources and bad values of staff may lead to substandard health care. For example, in South Africa violence and abuse in psychiatric facilities still continue today. A study investigating the present state of violence and abuse towards patients in four wards of specialized psychiatric hospitals in South Africa was conducted. A very simple questionnaire was distributed to 129 participants eliciting information on their experience with violence in the ward. Results indicated that 52% of the patients reported being physically abused, with sexual abuse being reported by 18.9% of the sample and verbal abuse by 37% of the sample (Lucas & Stevenson, 2006). These incidents emphasise the need for effective legislation to protect not only the patient's rights, but their safety as well. The history of psychiatric services, and need for mental health advocacy, is discussed in more detail in section 2.8.6.

All people have the right to medicines and treatment that are safe and efficacious and medicines, whether 'Western' or traditional, should fulfil the same uniform standards, tests and trials before being made available to the public. Achieving this goal is one of the main objectives of the Indigenous Knowledge Systems [Health] Lead Programme at the MRC. The IKS has four core research objectives including: (1) IKS research and development (2) IKS knowledge development and management (3) IKS utilisation and business development (4) IKS for community social impact and health generations. One of their main objectives, under

their research and development competency, focuses on research into traditional systems of health care by evaluating the effectiveness of traditional remedies through internationally accepted scientific methods (South African Medical Research Council, 2008). In their procedures to assess traditional claims for health benefits and/or cures, they provide specific details on the steps required for a traditional healer to make a claim for a traditional medicine used for life-threatening and chronic conditions, focussing on malaria, hypertension, HIV and AIDS, Tuberculosis, Cancer and Diabetes.

According to the South African Medical Research Council (2008), there are three study types which medicines must pass through to be considered effective and safe:

1) Safety and Toxicology. This tests the traditional medicine in a non-human primate model. The duration of this phase appears to last for five months – three of which are utilised for the safety study itself, and the remaining two months are used to collate and analyse the results and produce a comprehensive report of the findings.

2) This stage tests the safety and possible side effects of a specific herb which involves a limited number of healthy human volunteers. The numbers of participants ranges between 200 and 500 and this phase not only tests for safety of the particular herb, but also helps establish the most suitable dosage.

3) The third phase of the trial involves thousands of human volunteers to determine whether the herb has any positive treatment effects for the patient. People who may be suffering from a disease for which the medicine is being developed are therefore given an opportunity to participate in the study. Presently there has not been a single African Traditional Medicine that has successfully passed the requirements of Phase II or Phase III that have been explicated above. Nevertheless, once a specific medicine has passed Phase III, it can then be passed through the Medicines Control Council.

Additionally, the IKS (Health) Lead Programme houses the Tramed III database, formerly known as SATMERG, which consists of an enormous inventory of information on traditional medicines and medicinal plants and has been donated by Noristan Pharmaceutical. The South African Traditional Formulary is a database concerned with claims for cures. All claims presented at the IKS are therefore documented, and when a traditional healer contacts the Department of Health (DOH) claiming that they can cure a particular illness, the DOH refers

them to IKS. Directly obstructing this process is the fact that many traditional healers do not want to divulge their treatment secrets and have them undergo the scrutiny of this research as they believe their treatments will then be stolen (T. Spotose, personal communication, July 28, 2008) The IKS has also undertaken the enormous task of mapping the traditional health practitioners in the country with GPS. This project has already been completed in 3 districts in Kwa-Zulu-Natal, and has had large success rates. The data collected from this mapping includes the location of the traditional healers', their specialities, their proximity to schools, clinics, hospitals, and the populations in their surrounding areas. This information is invaluable and it is hoped that this programme will rollout, not only to other districts in KZN, but to other provinces as well (South African Medical Research Council, 2008).

2.6.2 Occult or Supernatural Powers

According to Nyika (2007), in order too practice "supernatural" traditional medicine, one is supposed to be a spirit medium, giving the ancestral spirits an opportunity to diagnose the cause of illness and describe the appropriate treatment. As mentioned previously, *sangomas* often use bones, seashells and other objects as a tool to communicate with their ancestral spirits. The *sangoma* throws the bones and depending on the specific way the 'bones' land, the ancestral spirits send messages to the healer. In other instances, the ancestors respond to the *sangomas* questions directly, by whistling out words from the rafters. The author notes that health problems under the supernatural branch of traditional medicine are seldom diagnosed as being caused by biological malfunctions, but rather by witchcraft or angry ancestral shades. In many cases, treatment includes a ritual sacrifice to appease the ancestors, or ritual and magical strengthening of both people and possessions, since causes of illness and misfortune are usually diagnosed to be as a result of witchcraft or angry ancestors.

For obvious reasons it is difficult to measure the effectiveness of treatment that fits into this particular branch of traditional medicine, since supernatural processes presumably go beyond the comprehension of humans (Nyike, 2007). However, according to Nyike (2007), it is the common practice of combining the supernatural and herbalist branches of traditional medicine that is associated with negative outcomes. The prescription of traditional herbs in combination with rituals, are common in order to treat the perceived spiritual causes of illness. Furthermore, it has been reported that some fanatic believers of the supernatural are responsible for muti killings. These occur when an individual is murdered for their body parts. Their bodies can either be sacrificed or used as medicine to rid the community of evil, or to confer special privilege to those responsible for the murder. Ngubane (1986) cites 30 cases of

muti murders that occurred in a 5 year period in Swaziland. The murders were typically associated with the removal of genitalia and body parts for to make "muti" (treatment). In the examples provided by Ngubane (1986), in order for the sacrifice to be effective, it was essential that the victim cried out in pain while their body parts were being removed. Consequently, the targeted body parts are cut from the body while the person is still alive. However, such practices are not accepted by the majority of traditional healers.

2.6.3 Simple Surgical Procedures

The literature suggests that blood-letting, cupping and scarification may be the most frequently used surgical procedures performed by traditional healers. According to Chavadunka, (1994), blood letting is often the method used to cast out an illness. Holes are made into the ground, and the patient's blood is poured into these holes to make the sickness go into the holes. The cupping horn is used to treat severe headache, rheumatism, painful abdominal conditions and other disorders in which severe and continuous pain is experienced. In addition, scarification involves making a number of superficial incisions on the skin to allow the illness to come out of the body (Abdool Karim et al., 1994). If the cause of the illness is perceived to be bewitchment, a number of rituals may be used in order to get rid of the spell, including the induction of enemas, vomiting, whistling, blood letting and even animal sacrifices (Abdool Karim et al., 1994).

It is no surprise that many of the traditional healers' practices described above have been found to be rather perilous (Chipfakacha, 1997; Garba & Deshi, 1998; Green & Makhubu, 1984; Luyckx et al., 2004; Peters, Immananagha, Essien, & Okott, 2004). For example, a study conducted with 81 traditional healers in Botswana reported that when healers performed 'bloodletting' on a patient some reported that they would use their own mouth to suck the blood (Chipfakacha, 1997). Similarly, a study conducted in Nigeria found that 77% of patients who had consulted traditional healers had received incisions with un-sterilized blades as part of their treatment (Peters et al., 2004). Enemas are often reported to prevent childhood diarrhoea, which has the potential to worsen dehydration. Induced vomiting may be dangerous for patients who have weak hearts or those with TB (Green & Makhubu, 1984).

Furthermore, in addition to the potential harm to patients described earlier as a result of various herbal treatments, consulting with a traditional healer has been found to result in a delay in receiving essential biomedical treatment. This delay can have negative consequences for the patient. For example, a qualitative study interviewing 23 traditional healers in Nigeria

investigated the perceptions of traditional healers regarding causes, symptoms, and treatment of uncomplicated malaria in addition to their referral practices. Results indicated that despite traditional healers not being familiar with the signs and symptoms of malaria, referral to biomedical professionals was rare. According to the healers, malaria is perceived as an environmentally related disease, caused by heat from the scorching sun. The few healers that did refer patients to biomedical professionals only did so after several stages of unsuccessful traditional treatment, which resulted in long delays of about two weeks before appropriate treatment was received (Okeke, Okafor, & Uzochukwu, 2006). Additionally, a study conducted in sub-Saharan Africa assessed the relationship between consulting a traditional healer and increased morbidity and death. Results indicated that the treatment delay (between the onset of TB symptoms and anti-tuberculoses treatment) for patients who consulted a traditional healer prior to seeking Western medical treatment was significantly longer (Barker, et al., 2006).

2.6.4 Treatment Prescribed by Traditional Healers for Mental Health Concerns

At the present time, there are no comprehensive studies focusing specifically on indigenous treatment of the mentally ill, and those that attempted this task focus more on psychotic disorders (Koen et al., 2003; Mzimkulua & Simbayib, 2006; Peltzer, 1999; Robertson, 2006; Thorpe, 1992). For example, Mzimkulua and Simbayib (2006) interviewed 4 Xhosa speaking traditional healers, whose patients were being treated at the psychiatric hospital in order to determine how they manage psychosis. A number of treatments were described by the healers, such as the cleansing of the patient's home through *intlombe* (traditional healers singing and dancing), to evocate evil spirits. In order to cleanse the patient, vomiting through the nose (*gabhisa ngentloko*), the mouth (*gabhisa*), and steaming in herbs (*futhis*) were commonly reported. A laxative herb was prescribed to patients in order to cleanse their stomach (*peyita*) and the *gwadisa* treatment to help the patient relax involved inhaling the smoke of the herbs through the nose. Similar findings were found in a study of 236 Xhosa patients with schizophrenia in the Western & Eastern Cape. The patients completed a structured interview (DIGS) as well as specific questions on their use of traditional treatment. Of the 236 participants, 198 (84%) reported that they had previously consulted a traditional healer, and adhered to the treatment prescribed. The most frequently reported treatment prescribed included: taking an oral solution (N =109), taking an oral solution/tablet to induce vomiting (N = 9), washing (N = 61), enema (N = 33), use of snuff (N = 23), slaughter of cattle (N = 2), steam (N = 24), wearing of beads (N = 7) and cutting of own skin with a sharp instrument (N = 14) (as described by Koen et al, 2003).

At the present time, there are no comprehensive studies focusing specifically on indigenous treatment of the mentally ill, and those that attempted this task focus more on psychotic disorders. Chapter 4 addresses this gap by asking answering the following question:

What are the specific treatment practices for mental disorders used by South African traditional healers?

2.6.5 Effectiveness of Traditional Treatment Prescribed for Mental Health Concerns

A few studies have been conducted in South Africa on the satisfaction of patient's who consulted a traditional healer for their mental health concerns. Ensink and Robertson (1999) examined the experiences of 62 African psychiatric patients and their families with the services provided by Western psychiatric and traditional healer services. Sixty-one percent of the sample had consulted with a traditional healer within the previous year, which included faith healers (34%), diviners (24%) and herbalists (13%). Most of the patients in the study suffered from severe mental illnesses ranging from severe depression to schizophrenia and bipolar disorders. Results indicated that patients and their families were satisfied with the service provided from psychiatric services and from herbalists and although patients reported to be satisfied with the service provided by faith healers, their families were less convinced. However, in regards to diviners, both patients and families articulated their dissatisfaction with these services provided.

A similar study was conducted with a community sample of traditional healer patients in Khayelitsha, Cape Town (as described by Robertson, 2006). Although the number of participants was not disclosed, the patients presenting problems in this study were not severe, ranging from seeking a love potion to alcoholism with family violence, involving some degree of anxiety or depression in most clients. Results indicated that two-thirds of the clients felt that the treatment they received from traditional healers was fully effective, and over 90% reported that they were satisfied and would consult healers again. The degree of satisfaction did not differ between types of traditional healer. Although the methodology of the two studies does not allow the authors to be definitive about the underlying reasons for the differences in satisfaction expressed, the nature of the client's illness seems one of the likely factors.

Despite the evidence that many patients may be satisfied with the treatment provided by traditional healers, there is presently no data available to suggest that they are effective in treating the mentally ill. A number of suggestions have been put forward by researchers

attempting to explain how traditional healers are effective in healing their patients. While some compare the therapeutic techniques of traditional healers to Western psychotherapists (Bührmann, 1984; Rudnick, 2004) or spiritual advisors (Cheetham & Griffiths, 1982), others claim that the improvement in patients receiving treatment by traditional healers is due to the placebo effect (Ataudo, 1985; Gumede, 1990; Hewson, 1998). Although there is some evidence to suggest that intercessory prayer may be effective in treating a number of diseases (Byrd, 1988; Dossey, 2003) the findings of a Cochrane Review on this issue resulted in inconclusive findings (Roberts, Ahmed, & Hall, 2007).

In summary, treatments prescribed by traditional healers for mental illness have often not been rigorously evaluated, nor does it appear that they are always properly prepared or standardized. The treatment of patients with severe mental illness is of particular concern since they are both the most difficult to treat, and if the patient is aggressive this can make them vulnerable to abuse (Ensink & Robertson, 1999). Despite the lack of evidence available on the efficacy of traditional healer in treatment mental illness, due to the devastating effects of the HIV epidemic, many countries are looking to all available resources in an attempt to alleviate some of the burden. Since traditional healers are widely dispersed throughout the communities were there is little or no Western resources available, many believe there is potential in collaborating with this group of healers. The next section will look at views on collaboration and collaborative efforts existing between Western and traditional health professionals.

2.7 Bridging the Gap between Traditional and Western Medicine in South Africa

This section will begin by describing the varying views on the inclusion of traditional medicine into the health care system, and the progress the South African government has made toward the official recognition, institutionalization and employment of African traditional medicine. In addition, collaborative efforts already in place will be discussed, as well as some of the issues that arise when trying to negotiate terms of collaboration between Western and traditional practitioners.

2.7.1 Views on Collaboration

Due to the concerns regarding the safety of traditional medicine as well as the racial discrimination enforced during the apartheid era, the 1974 Health Act prohibited traditional healers from practicing medicine. Nevertheless, despite these laws traditional healers continued to practice on South Africans of all socio-economic levels. However, after the

African National Congress (ANC) came into power in 1994, the introduction of The White Paper for the Transformation of the Health System in South Africa (DOH, 1997) included traditional healers when it described the broader primary health care system. It claimed that consumers would be granted their right to consult a health care provider of their choice and that legislation would be altered to assist the controlled use of traditional practitioners. Furthermore, due to the scarcity of resources and personnel, utilising every available resource was argued as essential if South Africa were going to meet the health care requirements of the country, specifically in response to the HIV & AIDS epidemic (UNAIDS, 2000, 2002)

Broadly speaking, there are three pathways for collaboration between Western medicine and traditional health practitioners: 'incorporation' which suggests that traditional healers be incorporated into the primary health care service where they can play the role of village health workers; 'co-operation' which implies that both traditional and Western health systems remain autonomous and each retains its own methods of operation and explanation; and 'total integration', in which a 'new' system of healing through the merging of the two different medicinal systems (Pillsbury, 1982).

It is not surprising that views on collaboration with traditional healers in South Africa vary substantially. For example, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) both advocate that national governments officially recognize traditional healers as partners in health care, and urge the integration of traditional medicine into Western biomedical systems (WHO-UNICEF, 1978)

The South African Medical Association (SAMA) believes this collaboration and integration will ensure safety standards. Robertson (2006) argues that collaboration should be promoted, but further knowledge and debate is required about the most appropriate way (specifically for mental health practitioners) to collaborate with traditional healers, and on what basis this should be founded. On the other hand, Doctors for Life (DFL) (an international organization that represents a large number of medical doctors, dentists, veterinarians and other professionals) are against any collaboration with traditional healers, due to what they see as the unscientific approach of most of South Africa's traditional healers. "[Doctors for life] are of the opinion that any form of medicine that is not based on empiric data is potentially (and ultimately) harmful to the patients in need" (Doctors for Life, 2007).

Studies investigating traditional healers' attitudes towards collaborating with Western health care professionals suggest a readiness for partnership. For example, studies investigating hearing impairment (De Andrade & Ross, 2005), HIV and AIDS (Okome-Nkoumou et al., 2005; Peltzer, Mngqundaniso, & Petros, 2006), TB (Barker et al., 2006), and malaria (Okeke et al., 2006**),** report that traditional healers are willing to collaborate with Western practitioners and the practice of referring patients is common. In a study investigating the beliefs and practices of hearing impairment, 15 traditional healers were interviewed about their views on collaboration with Western professionals. A majority (12) of the healers reported collaborating. Responses indicated that traditional medicine is viewed as a first line of treatment and if the patient does not respond to treatment they are referred to the Western doctors (De Andrade & Ross, 2005).

Specifically looking at mental illness, a qualitative study conducted in Uganda investigated the attitudes of 10 indigenous, 10 religious and 14 allopathic healers towards each other in relation to their effectiveness in treating mentally ill patients (Teuton et al., 2007). Results indicated that the indigenous and religious healers are tolerant towards 'Western" medicine. The indigenous healers viewed Western doctors as being capable to identify and treat 'madness' caused by non-spiritual factors (ie. AIDS). However, they were unable to treat problems more spiritual in nature. The religious healers incorporated Western diagnostic and treatment methods into their practices (e. g. asked clients about blood test results and referred them to counselling). Although Western doctors made little reference to religious healers, their relationship with indigenous healers was characterized by tolerance and conflict. Reports of indigenous healers physically abusing their patients were described, while others suggests that many psychiatric conditions could deteriorate as a result of consulting with these healers. Finally, the relationship between the indigenous and religious healers were characterised by conflict. Indigenous healers regarded the belief system of religious healers to be incompatible with their own, while religious healers frequently referred to the practices of indigenous healers as 'witchcraft'. It was commonly reported that indigenous healers create conflict within the community in order to make money out of chaos and misfortune (Teuton et al., 2007). The figures for mental health practitioners in South Africa are unavailable, though given the strong leaning towards medical model and scientific training similar to those in Uganda, it is likely that many Western mental health professionals in South Africa are similarly inclined

2.7.2 Global Recommendations for Collaboration with Traditional Healers

The HIV/AIDS pandemic has forced public health officials throughout the developing world to reconsider their attitude towards traditional medicine. This is aided by the recognition that traditional healers may be instrumental in preventing the spread of the HIV / AIDS virus, as well as being able to care for the sick – particularly in rural areas that have very few resources that have the capacity for conventional medical facilities or practitioners. Perhaps most importantly, however, is the possibility that medicinal plants may actually hold the key to fighting the HIV / AIDS virus (WHO, 2002).

Despite these varying views on collaboration and the potential practical difficulties that may arise, over the past several decades, support for traditional medicine has dramatically increased worldwide. Resolutions urging member states to adopt national policies and regulation on traditional medicine have been passed by the World Health Organisation and the Southern African Development Community (SADC). In addition to an ATM resolution, the African Union's Plan of Action on the decade for African Traditional Medicine (2001-2010) is celebrated with an annual day of recognition on August 31st (DOH, 2008)

A number of international organisations including the WHO and UNAIDS have gone so far as to provide extensive encouragement and guidance for the collaboration between Western medicine and traditional healers in order to combat the AIDS crisis (UNAIDS, 2006). Some core recommendations (King, 2005) are: (1) dialogue on matters of mutual interest, (2) referrals from one health system to another (3) exchange of information on management of illnesses/diseases and exchange of materials and technology used in preparation and dispensing treatment. According to the author, the most important element to a successful collaboration is the selection of genuine healers with competence in managing diseases/illnesses and trustworthiness and a standing in the community. Although these recommendations appear useful, collaboration is much more difficult to achieve in practice. Kayombo et al. (2007) interviewed 110 traditional healers treating patients with HIV & AIDS in order to elicit their views on collaboration. Findings indicated that for an effective collaboration to be sustainable the key elements prescribed by King (2005) must be present, in addition to, patience, tolerance, respect and trust. The problem with these findings is that these characteristics can take years to develop.

A number of African countries have initiated collaborative efforts between biomedical and traditional health practitioners. For example, organizations such as the Traditional Healers and Modern Practitioners Together Against AIDS (THETA) in Uganda, Tanga AIDS Working Group (TAWG) in Tanzania and the Zimbabwe National Traditional Healers Association (ZINATHA) in Zimbabwe have been established. These groups and associations are examples where biomedical healthcare practitioners are collaborating with traditional healthcare practitioners (Kayombo et al., 2007). South Africa has made efforts to officially recognize traditional healers as health care providers by the passing of the Traditional Health Practitioners Bill and the draft policy on African traditional medicine which has recently been gazetted for public comment. These efforts will now be discussed in more detail.

2.7.3 Recognition and Regulation of Traditional Medicine in South Africa

The degree of recognition of African Traditional Medicine by the South African government continues to increase. In 2006 the Directorate of Traditional Medicine was established to co-ordinate and manage related initiatives within the Department of Health. African Traditional Medicine research and development has also been funded by the government in an effort to manage and control diseases. Additionally, two formal legal structures were put in place to recognize African Traditional Medicine in South Africa: The Traditional Health Practitioners Bill establishing the Traditional Practitioners Counsel, and the draft National Policy on African Traditional Medicine in South Africa.

Traditional Health Practitioners Bill

Traditional healers have been members of formal and informal associations, which made it difficult to reach a consensus that includes all traditional healers in South Africa. Today, many healers currently practicing in South Africa are members of the Traditional Healers Organization (THO), one of the largest associations for traditional healers in South Africa established in 1970. It counts 69 000 traditional healers in Southern Africa as its members, 25 000 of those residing in South Africa alone (Richter, 2003). It is mandatory for all traditional healers who want to join the THO to attend a one-day workshop, introducing THO and their aims and objectives, in addition to a five-day workshop on traditional primary health care. A good character reference is also required prior to being accepted as a member (Richter, 2003). It costs 140 ZAR a year to be a member of the THO. Upon completion of registration each member is issued a THO member identification book, which includes a picture of the

registered healer (looks similar to a passport). (J. Thandi, personal communication, November 16, 2007)

More recently, South Africa has moved towards officially recognizing traditional healers. After consultation with various stakeholders, including non-governmental organizations, research institutions, traditional healer representatives, and private sector organisations, the South African government has developed new legislation and policies to regulate and promote systems of indigenous knowledge. This formed the draft Traditional Health Practitioners Bill that was approved by parliament in September 2004 and was enacted on 11 February 2005 (Sidley, 2004). This Bill allows for the estimated 200 000 traditional healers in South Africa to practice a legal medical trade, stipulates sick leave, and offers treatment for a long list of diseases using traditional methods. The Bill is the first step in the process to register traditional healers with the Health Professionals Council of South Africa, and is an attempt to standardize traditional medicines through the Medicines Control Council (Sidley, 2004). Through regulating traditional healers it is hoped that South Africa can preserve an invaluable cultural heritage while at the same time safeguarding the health and well being of its people.

The proposed Traditional Health Practitioners Bill includes a broad definition of traditional health practitioner as "a person registered or required to be registered in terms of this Act and includes traditional birth attendants and traditional surgeons". It outlines a number of objectives and functions of the proposed Traditional Health Practitioners Council of South Africa (the Council) which would have general powers including registering people as traditional health practitioners, establishing registers for various traditional health practitioners and making rules to further the objectives of the Act. The Council will have a maximum of 25 members and will consist of registered traditional health practitioners, a representative from the Department of Health, a legal representative, a medical practitioner of the Health Professions Council of South Africa (HPCSA), and others. The Council will meet at least twice a year (Richter, 2003; Traditional Health Practitioners Bill, 2003).

Section 19(1) is a core component of the Act stating "No person shall be entitled to practice as a traditional health practitioner within the Republic unless he or she is registered in terms of this Act". However, the Bill does not provide details on what the minimum requirements are or what training or practice criteria have to be fulfilled for a person to be regarded as a traditional health practitioner. It does, however, provide a description of a guilty offender of the bill as one who "diagnoses, treats or offers to treat, or prescribes treatment or any cure for

cancer, HIV/AIDS or such other terminal diseases as may be described (Richter, 2003; Traditional Health Practitioners Bill, 2003). Interestingly, the Bill requires the Minister to prescribe the necessary qualifications on recommendation of the Council. As a further consequence, unregistered traditional health practitioners will not be able to recover remuneration "in respect of any act specially pertaining to the occupation of a traditional health practitioner".

However, governmental processes have delayed the implementation of this bill, up to this current day. One of the major critiques in opposition to the present legislation is that it failed to include concrete avenues through which this legislation could be implemented (Pefile, 2005). Unity of traditional healers will be lengthy and complicated (Devenish, 2005), and it is possible that the time frames laid out in the Bill were unrealistic. Other Bills have also been affected by lack of communication from the South African government and between the provinces.

National Policy on African Traditional Medicine

The World Health Organisation (WHO) estimates that in the 2000, 25 countries reported having a National Policy on Traditional Medicine (WHO, 2001b). It is clear, according to the WHO that the necessary regulatory and legal mechanisms are in place to ensure access, safety and efficacy of therapy where these policies are present. While the national recognition and regulation of traditional medicine varies greatly according to a comparative study of 123 countries, it is clear that the process of integrating traditional medicine into the national health care systems follows six predictable steps:

- Adaptation of a national policy on traditional medicine
- Establishment of a national focal point – typically a National Institute of Traditional Medicine
- Establishment of a national Federation or Council of Traditional Health Practitioners and/or a national register and licensing system
- Establishment of a national strategy or action plan to direct the process through which traditional medicine will regulated
- Development of a pharmacopoeia or regulatory mechanism to register and control traditional medicines, with emphasis on safety and quality, and

- International collaboration (including the WHO) to exchange information and harmonise policies and regulations.

Proceeding through these six steps (WHO, 2001b), the South African government published a draft national policy on African Traditional Medicine (ATM) aimed at the institutionalisation of African Traditional Medicine (DOH, 2008). This did not include integrating ATM with allopathic medicine as it is intended for the two systems to function in parallel within the health care system. This development supports the African Union's Decade of Traditional Medicine (2001-2010) urging the integration of ATM into public health systems of all member states by 2010. South Africa's draft policy recommends the creation of legislation to regulate ATM including a registration process for ATM products, intellectual property provisions and formalisation of the ATM practitioner profession. Furthermore, the policy recommends that a National Ethics Committee for African Traditional Medicine research be established and that a national pharmacopoeia be developed (DOH, 2008).

Ideally, the successful implementation of the Traditional Health Practitioners Bill and draft African Traditional Medicine (ATM) policy could potentially play a pivotal role in collaborative efforts. One of the main concerns of Western practitioners is the potential harm that traditional healers' practices cause to patients (Doctors for Life, 2007). Establishing a body to regulate the efficacy, safety and quality of traditional health care services, and the possibility of some kind of control over the standards and quality of traditional healing could potentially diminish their concerns. Part of this could entail enabling a mutual referral system to be established between the two sectors. The Bill could make it possible to draw up a list of registered and properly qualified traditional healers for every region or district. This could serve as a guideline for doctors and clinic staff should they decide to refer a patient.

2.7.4 Interventions for Educating Traditional Healers

Studies looking at traditional healers' perceptions of sexually transmitted infections and HIV infection were conducted as early as the late 1980s. Then in the early 1990s when WHO recommended that traditional medicine be included in national responses to HIV, attempts to bring biomedical and traditional health care together for people living with HIV began. Early attempts to combine the best of both systems included a variety of projects that looked at the usefulness of traditional herbal remedies for the treatment of HIV-related illnesses. Another form of collaborative projects involved training traditional healers as educators and

counsellors to disseminate information on HIV and sexually transmitted infections in their communities and to their peers (UNAIDS, 2000, 2002).

Therefore, a majority of the literature available on traditional healers is concentrated on their knowledge, attitudes and practices. A great deal of this research focuses on HIV and AIDS (Moss et al., 1999) and Sexually Transmitted Infections (STI's) (Zachariah et al., 2002; Kusimba et al., 2003; Ndubani & Höjer, 1999). Cancer (Steyn & Muller, 2000), TB (Colvin et al., 2003) and diabetes (Peltzer et al., 2001) are also cited in the literature. Other health concerns include eye services (Courtright, 1995; Poudyal, Jimba, Poudyal, & Wakai, 2005), hypertension (Risenga, Botha, & Tjallinks, 2007), urethral and vaginal discharge (Ndulo, Faxelid, & Krantz, 2001) oral health (Lewis et al., 2004), ear, nose and throat disease (Njoroge & Bussmann, 2006), malaria (Orwa, Mwitari, Matu, & Rukunga, 2007; Makundi, Malebo, Mhame, Kitua, & Warsame, 2006; Gessler et al., 1995), cleft lip and palate (Dagher & Ross, 2004) and epilepsy (Baskind & Birbeck, 2005).

In most of these studies, one of the most prominent research aims was to identify and reduce the dangerous practices of traditional healers. In doing so, a number of studies have assessed interventions aimed at lessening the harmful effects of some traditional healer practices and encouraging health promotion, mostly in the area of HIV and AIDS (Green et al., 1995; King & Homsey, 1997; Peltzer et al., 2006; Rudolph, Ogunbodede, & Mistry, 2007). There have also been interventions aimed at TB (Colvin et al., 2003; Peltzer et al., 2006) and bone setting in primary fracture care (Onuminya, 2006). For example, traditional healers have been involved in a number of HIV and AIDS prevention programs (Green 1994, Green et al., 1995; UNAIDS 2000, 2002). The interventions, conducted primarily in Africa, reveal that traditional healers have the potential to be a valuable resource in caring for people living with HIV and AIDS and in preventing HIV infection (Green, 1994; Green et al., 1995; King & Homsy, 1997; UNAIDS 2000, 2002), although none of these were randomized control trials. For example, an intervention study that adopted pre- and post- test design showed an improvement in traditional healer's knowledge and attitudes on HIV and AIDS immediately after the training (Somse et al., 1998).

A more recent randomized controlled trial was aimed at increasing traditional healers HIV knowledge, STI management strategies, and levels of referrals to biomedical personnel. Two hundred and thirty three participants completed an interviewer-administered, semi-structured questionnaire immediately before and seven months after the intervention. The authors found

that traditional healers improved and retained their knowledge of HIV and AIDS and STIs. However, the intervention failed to adequately improve knowledge of TB or increase referral of patients to biomedical health care personnel (Peltzer et al., 2006). On the topic of TB, the potential role of traditional healers as TB supervisors was found in a study conducted by Colvin et al. (2003). Treatment outcomes of patients with a traditional healer as their supervisor and supervision under other community health workers were compared. Of the 275 patients with known treatment outcomes, 48 patients were supervised by traditional healers and 227 patients supervised by other community members. Results indicated that there was no significant difference in treatment outcome between these two groups of health professional**s.** Furthermore, one on one interviews with traditional healer patients who had completed treatment indicated high levels of satisfaction. Most of the patients reported that traditional healers should be DOT supervisors given their highly respected role in the community. Many reported that traditional healers were very easy to access, and showed a caring attitude towards their patients, constantly enquiring about the general well-being of the patients they supervised.

However, only one study was found assessing the effectiveness of an intervention focussed on traditional healers and mental health practices. Adelekan, Makanjuola, and Ndom (2001) conducted a training program for 43 traditional healers on various aspects of mental health, including concepts of normality and abnormality; types of mental illness; treatment of mental illness including follow-up and after-care; and relapse preventions, amongst others. Although 43 traditional healers were present at the pre-test phase, only 27 completed both pre and post test assessments. Results indicated that prior to the workshop traditional healers could recognise symptoms of severe mental illness, but that they often expressed a strong belief in supernatural factors as a cause of mental illness. However, following psycho-education a significant improvement in the aetiology of mental illness was found, in addition to a reduction in the use of beating or restraining their mentally ill patients.

At the present time, it is clear that the present collaborative efforts involving Western and traditional practitioners take on the form of a one-sided unidirectional, educative approach. Since collaboration by definition should be a two way process, this approach emphasizing the training of traditional healers' has been criticized (Wreford, 2005a, 2005b). At the present time, it is not regular practice for Western doctors to refer their patients to traditional healers. Presumably when traditional medicine becomes more standardized and evidence based this practice would change. However, Hillenbrand (2006) interviewed 17 traditional healers in

order to investigate their own assessment of their strengths and weaknesses in regard to treating patients. Results indicated that both 'Western' and traditional healers agree that traditional healers can learn a substantial amount from their 'Western' counterparts. For example, the healers were aware of the potential problems that can arise if the patient receives the wrong dose of herbs, and some have even reported altering their practices to include writing out a "prescription" to help patients remember their instructions. Another major concern reported was the difficulty in regulating "charlatans". The healers claimed that it is these charlatans that are ruining the reputation of genuine bona fide traditional healers. It was agreed that there is a need to put in place standards and regulations that not only assess the qualifications of competent traditional healers, but the effectiveness and safety of their medicines as well. Therefore, it appears traditional healers are aware of the many weaknesses of their practice and are eager to collaborate with the conventional medicine sector.

Although various intervention strategies have been adopted to educate traditional healers in the fundamentals of a number of health care issues, as shown above, their effectiveness remains unknown. To date, no systematic review has attempted to determine whether interventions to educate traditional healers result in positive outcomes, such as knowledge gain, behaviour change and referral of patients to Western health professionals. Chapter 5 addresses this gap by answering the following question:

Are interventions for educating traditional healers about STD and HIV medicine efficacious?

A number of the interventions aimed at traditional healers described above were conducted by NGOs. A number of NGOs, including mental health advocacy groups, have recognised the potential of educating traditional healers in various aspects of mental health care. For example, certain branches of the counselling NGO, Lifeline, provide workshops and training to traditional healers, that focus on basic counselling skills, personal growth and HIV and AIDS awareness. In addition, the South African Depression & Anxiety Group (SADAG) has been working with traditional healers for over 4 years to increase mental health awareness of traditional healers in rural communities in South Africa.

2.8 Mental Health Advocacy Groups and their Role in South Africa

The following section will discuss the historical aspects of mental health care in South Africa and the human rights violations in psychiatric institutions. Additionally, an introduction to the mental health advocacy groups presently operational in South Africa will be provided. Furthermore, the important role advocacy groups' play in addressing barriers to mental health will be addressed, with a focus on mental health literacy.

2.8.1 The Need for Mental Advocacy Group in South Africa: A Brief History

The idea of mental health originated in 19th century Europe, and is therefore a 20th century Western construct that arrived in South Africa by imperialism and colonialism. In 1846, the prison colony on Robben Island was converted into a hospital for lepers, lunatics and other patients who were chronically ill. By 1912, the Robben Island Infirmary housed 500 mental patients. These facilities were known for their dreadful conditions and ghastly facilities, and reports on the mistreatment of patients were numerous (Emsley, 2001). Although racial categorization was not a characteristic of these facilities at this time, by the mid 1860s classification of lunatics by "race" and gender was common practice. Between 1860 and 1899, in addition to the promulgation of 'lunatic laws' in each of the four future provinces of South Africa a number of 'lunatic asylums' were built. These included the Fort England Mental Hospital in Grahamston, Town Hill Asylum in Pietermartizburg, Valkenberg Lunatic Asylum in Cape Town, and the Pretoria Lunatic Asylum (Makepeace, 1969).

The objective of these asylums was to ensure that mentally ill patients remained isolated from the community. Mental health service planning that occurred under apartheid was unsystematic and services that were provided were uncoordinated. It emphasized custodial care in large institutions, primarily for the severally ill, and was notably rather ineffective (Foster et al., 1977). The approach was curative and residual rather than developmental and preventative (Freeman, 1992). Furthermore, racial discrimination, paternalism and some degree of privatization (Foster et al., 1977) were common features of mental healthcare services in South Africa.

However, for the unfortunate majority of the South African population, apartheid legislation maintained callous and inhumane practices in mental health facilities against the black population (Foster et al., 1997). Under apartheid services for blacks in South Africa were minimal. For example, the Weskoppies Mental Hospital had about 900 beds for Bantu patients, most of them were admitted on certification. By 1978, the situation of mental health

care for blacks seemed to have deteriorated even more. This is shown in the following quote by Foster et al. (1997):

> *"Makeshift, under resourced asylum facilities for blacks were justified on the grounds that they approximated 'indigenous' lifestyle and were therefore preferred by black patients. In 1979, the Department of Health used 'cultural preference' as an argument to justify the failure to issue black patients with shoes"*

Further evidence of the inhumane practices in psychiatric facilities was reported when a delegation from the American Psychiatric Association (APA) visited South Africa and compiled a report criticizing racial bias in psychiatric practice by pointing out the destructive impact of apartheid on the mental health of Black South Africans. It appears that mental health services in South Africa have simply reflected the injustices and discrimination of the society in which they have been embedded. However, in response to these honest, although negative findings, government officials accused these American psychiatrists of promoting the special interests of certain anti-Apartheid pressure-groups (Domissee, 1987). Furthermore, a study conducted at the University of Cape Town in 1985 interviewed 176 previously held detainees and elicited information on how they were treated during detention. Results indicated that 83% of detainees were being physically tortured and all participants reported various psychological forms of torture, with 94% of the sample reporting declines in health as a result of the torture. The study recommended that torture should be eliminated from these institutions in South Africa and that professional bodies should fight against this kind of abuse (Foster, Sandler, & Davis, 1985).

The concept of mental health advocacy was initially developed as it was recognized that people with mental disorders were susceptible to human rights violations that included involuntary, long term detention in psychiatric institutions (Funk, Minoletti, Drew, Taylor, & Saraceno, 2006). Therefore, mental health advocacy was introduced as a means of combating stigma and discrimination and to promote the human rights of persons suffering from mental disorders (Emmet, 1998; Frese, 1998; Morselli, 2000).

2.8.2 Background on Mental Health Advocacy

> *"Advocacy is an important means of raising awareness on mental health issues and ensuring that mental health is on the national agenda of governments. Advocacy can lead to improvements in policy, legislation and service development" (WHO, 2003)*

The term comes from the Latin word meaning 'to speak to a matter or issue' (Morselli, 2000**).** In contemporary use today, it has come to mean speaking or writing in support of someone or something. Specifically in the field of mental health, advocacy refers to speaking on behalf of someone unable to represent himself due to illness (Morselli, 2000). Inherent in the definition of the term is the concept of action (i.e., pleading, urging, recommending). Advocacy implies taking action to achieve a goal, either on behalf of oneself or on behalf of another.

Mental health advocacy can be performed by several different types of organizations. No single organization or group has a monopoly over advocacy; rather it incorporates all stakeholders involved in advancing the mental health situation. In fact, in order for advocacy groups to be successful it often requires a combination of different partners to work together to achieve a common goal (WHO, 2003). These organizations can include non-governmental organizations (NGOs), general health workers, mental health professionals, policy makers and planners, family members of the mentally ill, and the mentally ill themselves (WHO, 2003).

It is now becoming customary that mental health consumers be involved in advocacy efforts aimed to improve services. Their involvement is essential to ensure mental health services are running democratically and to ensure services offered are relevant for the total population. Two international organizations that represent users are the World Network of Users & Survivors and the Pan African Network of Users & Survivors of Psychiatry. Although mental health professionals and consumer groups may hold diverse perspectives, collaboration between these two groups has the potential to lead to major advances in psychiatry (Stein & Emsley, 1998).

Although some countries have well established mental health advocacy networks, in many countries and regions, service users' organisations and other advocacy groups are weak or non-existent (Saraceno, 2001). In developed countries, mental health advocacy is active and in full expansion. For example, in the United States, the first mental health advocacy

organization was founded in 1909 (National Mental Health Association) and some countries in Europe began focussing on mental health advocacy in the early 1970s. On the other hand, many developing countries lack strong advocacy movements, which only exacerbate the dire situation for people with a mental illness. This is why the WHO urges countries around the world to develop active advocacy groups to put mental health on governments' agenda's (WHO, 2003).

According to the World Health Organization (WHO, 2003), the following are standard fundamentals of advocacy: Awareness-raising**,** Information**,** Education**,** Training**,** Mutual help**,** Counselling**,** Mediating**,** Defending and Denouncing. Although there is a lack of scientific evidence that advocacy actually improves the mental health of populations, mental advocacy organizations and their actions have lead to a number of encouraging outcomes in the arena of mental health care. For example, individuals suffering from mental disorders are now seen by society in a more positive way and consumers of mental health services have articulated their opinions about services required for the mentally ill. Increasingly, persons suffering from a mental illness are capable of making informed decisions about treatment options. Furthermore, the advocacy movement is believed to have considerably influenced mental health policy and legislation in a number of countries and is thought to be a major force behind the development of improved services in others (WHO, 2001a).

2.8.3. Mental Health Advocacy and Barriers to Treatment

Despite the evidence that there is effective treatment available for those suffering from a mental illness, very few receive appropriate treatment. The World Mental Health Surveys provide data on the help-seeking behaviour of over 84 848 community members in 16 countries. Results from South Africa found that only one-quarter of South Africans with a recent DSM-IV diagnosis received treatment in the year preceding the interview. Furthermore, approximately two-thirds of the respondents who sought treatment consulted with alternative and complementary medical providers (Wang et al., 2007). Additionally, even when patients present for treatment in primary care settings, they may be either under diagnosed or misdiagnosed. This results in the patient receiving inadequate treatment (Wang et al., 2007).

A number of barriers to accessing mental health care have been reported in the literature. For example, barriers to mental health care were assessed as part of a multinational study in ten countries, including South Africa, surveying advocacy group members suffering from mood

and anxiety disorders. Results of the ten countries reported that the majority (60%) of the respondents had a median delay of 8 years prior to seeking treatment (Seedat, Stein, Berk, & Wilson, 2002). The 404 South African respondents of this survey reported a number of reasons for delaying their treatment. These include not knowing where to go (33.2 %), wanting to handle the problem on one's own (30.9%), being given the wrong diagnosis (29.5 %), not finding an understanding professional (29.5 %), and embarrassment (22.2 %). Less frequent reasons expressed were fear of medication (20.5 %), lack of family support (11.2 %), mistrust of doctors (10.7 %), and belief that treatment would not help (9.6 %). More than 40% of the South African participants had consulted up to four doctors prior to receiving the correct diagnosis. Furthermore, the average time spent in treatment before being given a correct diagnosis was approximately 1–2 years. However, due to the sample population used (advocacy group members), it is difficult to generalize these findings to the South African population.

Despite these limitations, as this study reveals, there are a number of barriers to seeking treatment. In the following section mental health literacy and stigma will be discussed in more detail.

2.8.4 Mental Health Literacy

Historically, the mentally ill have been ostracized, abused, ignored and segregated. Today, while there is much more knowledge and information available concerning the etiology, progression and treatment available for the mentally ill, there still remains a great deal of fear and misinformation regarding mental illness. The term 'Mental health literacy' was first coined by Anthony Jorm and his colleagues, and is defined as the "knowledge and beliefs about mental illness that aid their recognition, management or prevention" (Jorm et al., 1997, p. 182). Jorm et al. (1997), states that mental health literacy consists of several components. These include:

- the ability to recognise specific disorders or different types of psychological distress;
- knowledge and beliefs about the risk factors and causes;
- knowledge and beliefs about self-help interventions;
- knowledge and beliefs about professional help available;
- attitudes which facilitate recognition and appropriate help-seeking; and

- knowledge of how to seek mental health information.

Most of the research investigating mental health literacy has focussed almost exclusively on depression and schizophrenia and utilized vignettes to elicit participant's beliefs. Since most studies focus on depression and schizophrenia (Angermeyer & Matschinger, 1996; Angermeyer, Matschinger, & Riedel-Heller, 1999; Jorm et al., 2000a, 2000b; Lauber, Nordt, Falcto & Rössler, 2001), they fail to elicit beliefs on other mental disorders such as panic and substance abuse disorders. Only a few studies have assessed other mental disorders such as alcohol and drug dependence (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999) and panic disorder (Angermeyer & Matschinger, 1996; Hugo, Boshoff, Traut, Zunga-Dirwayi, & Stein, 2003). Furthermore, methodologically, all studies assessing mental health literacy use vignettes to elicit participants' beliefs. As such, their conclusions are limited to the responses given to the cases presented and cannot be assumed to be identical to the participants responses in real life situations.

Findings of studies in the developed and the developing world report that mental disorders are not well recognized by the public, resulting in poor mental health literacy. For example, results of a nationally representative survey conducted in Australia on 2031 adults aged 18 to 74 revealed that only 39% of the sample identified depression (39%) or schizophrenia (27%) by name when presented with a vignette of someone suffering from these conditions. Therefore, members of the lay public were able to recognize that the person described had a health problem but many were unable to label the problem correctly (Jorm et al., 1997). Furthermore, a study conducted by Hugo et al. (2003) surveyed 667 participants in Cape Town, South Africa. Each participant was presented with a vignette of depression, schizophrenia, panic disorder or substance use. Their beliefs and knowledge concerning the vignette were then elicited. A majority of the participants reported that the problems described in the vignettes were stress related (76.8%), and talking about the problem (84.8%) and psychotherapy (69.7%) were the preferred treatment options. In addition, 54% reported that medication was not the best treatment option available as they were habit-forming, not reliable at preventing relapse and could only calm patients down.

There also appears to be a gap between the public and professional beliefs about the most appropriate treatment for mental disorders. Many studies have reported that the use of medications to treat psychiatric illness is considered to be the least recommended treatment for all mental disorders (Angermeyer & Matschinger, 1996; Fisher & Goldney, 2003; Hugo et

al., 2003; Jorm et al., 1997, 2000b; Lauber et al., 2001). For example, a study conducted by Goldney, Fisher, & Wilson (2001) reported that only 29.8% of the general population and 40% of those diagnosed with depression, reported a belief that medication can be helpful with this illness. This is despite the results of numerous national and international clinical drug trials that have provided evidence that medications used in psychiatry are effective and safe (Kaplan & Sadock, 1997; Stein & Gureje, 2004). This finding might be associated with the strong beliefs of laypersons about the harmful side-effects of sedatives and psychotropic medications.

Unfortunately low mental health illiteracy is not limited to the lay public; there is evidence that primary health care workers also exhibit low levels of mental health literacy. For example, a study conducted in Switzerland by Lauber, Nordt, Braunschweig, and Röessler (2006) interviewed via telephone a representative sample of mental health professionals (N=1073) and laypersons (N=791). The interviewees were randomly presented with a vignette depicting a person with either major depression or schizophrenia. In the mental health professional sample a 'non-case' vignette was additionally presented. Results indicated that in addition to laypersons reported low levels of mental health literacy, compared to psychiatrists and psychologists, fewer nurses, social workers, vocational workers and occupational therapists, recommended standard psychiatric treatment methods. Furthermore, a considerable number of mental health care professionals reported that the patient in the 'non-case vignette' recommended the patient consult with a psychologist or general practitioner indicating a possible problem with over diagnosis. Similarly, a study conducted by Dirwayi (2002) (as described by Ganasen, Parker, Hugo, Stein, Emsley & Seedat, 2008) assessed the knowledge of mental illness and attitudes towards the mentally ill of nurse's in the Western Province of South Africa. Results indicated that 94% of the sample did not correctly diagnose the disorders in the case vignettes presented to them. These findings warrant concern considering the first line of contact many South Africans encounter are these community health workers (Ganasen et al., 2008).

Correct recognition of disorders has the potential to influence help-seeking behaviour and holds serious implications for adherence to treatment (Jorm et al., 1997). This is revealed by a study conducted in Australia with a randomly selected population sample of 1,207 young people. Participants aged 12–25 were interviewed via a telephone survey and vignettes of a young person with either depression or psychosis were presented to the participants followed by a series of questions relating to the recognition of the disorder and recommended help-

seeking behaviours. Results indicated that the correct labelling of the disorder was associated with appropriate help-seeking and treatment preferences for both the depression and psychosis vignettes (Wright, Jorm, Harris, & McGorry, 2007).

There is some evidence to suggest that population-wide and individual level interventions designed to improve mental health literacy are effective (Jorm, Christensen, & Griffiths, 2006a). Beyond Blue is a program aimed to increase the awareness of depression in a number of states in Australia. In order to assess the programs impact, data from the 1995 and 2004 Australian national surveys, which included a measure of mental health literacy, were compared to assess whether states and territories that funded the program (high exposure states) differ from those who did not (low exposure states). Results indicated that there was a considerable change in beliefs and treatments in the high-exposure states, although recognition of depression in the vignettes improved substantially at a national level. Additionally, a review of three studies (2 RCTs) evaluating mental health first aid training in Australia resulted in promising findings. Results indicated a statistically significant difference 5-6 months following the training in recognition of disorders in vignettes and beliefs after treatments, including medications (Kitchener & Jorm, 2006). Although these findings appear promising, what we do not know is whether or not improved mental health literacy leads to improved mental health (Jorm, Barney, Christensen, Highet, Kelly, & Kitchener, 2006b).

There is much debate over the concept of mental health literacy in the developing world. To begin with, according to Ganasen et al. (2008), it is implied that the definition of mental heath literacy provided above refers to knowledge of evidence based mental disorders and their subsequent treatment. However, in the developing world, beliefs such as superstitions or cultural and personal beliefs are often given to explain the causes of mental disorders. Perhaps these beliefs should be included in the concept of mental health literacy in these countries. Secondly, one of the major obstacles in increasing the mental health literacy in the developing world is that mental health literacy is closely associated with general health literacy. Being able to comprehend written and oral information provided by health care professionals and adhere to the instructions on the label of medications may be an important contributor to mental health literacy. Therefore, methods of increasing mental health literacy that have shown to be effective in Australia and other developed countries may not be successful in the developing world where more than half of the population may be illiterate. According to Mubbashar and Farooq (2001), in the developing world mental health professionals will have to implement novel and innovative methods to increase mental health literacy in the

communities. Mental health literacy could be addressed through mental health advocacy groups in the developing world by collaborating with a variety of members of the community, including primary health care physicians, schoolchildren, teachers, and traditional healers.

In a non-systematic review of published articles on mental health literacy, Ganasen et al. (2008) summarized a strategy for improvement of mental health literacy in developing countries. These included:

- Improve mental health budgets of developing countries
- Effectively utilize existing mental health resources
- Identify economic and resource barriers that hinder mental health practice and policy
- Improve dissemination of mental health literacy information among the general population and especially health care workers
- Promote awareness campaigns, including workshops and training courses using all forms of media
- Educate and update traditional healers on newly acquired knowledge in the field without being dismissive of their longstanding cultural beliefs and formulate their inclusion in an appropriate referral system
- Train primary health care workers to identify and deal with common mental disorders
- Maximise the mental health literacy by promoting use of the internet

According to Jorm et al. (2006b), changing knowledge of mental illness is a much more feasible task than trying to change deep-seated emotional reactions to people with mental illness, otherwise known as stigma. Although one might think that improving the mental health literacy of the general population may also be important in terms of overcoming the stigma associated with mental illness, this is not necessarily true. Research suggests that clinicians generally report high levels of mental health literacy, but do not necessarily report low levels of stigmatizing attitudes toward the mentally ill (Jorm et al., 2006b). The concept of stigma will now be discussed in greater detail.

2.8.5 Stigma and its Effects

There are a number of varying definitions of stigma, however in general terms, stigma occurs when someone is described using discriminatory stereotypes and labels, and is often attached to people who suffer from a mental illness. According to Link and Phelan (2001) there are five components of stigma: labelling, stereotyping, separation, status loss, and discrimination

within the context of power differentials. *Labelling* occurs when people distinguish and label human differences. *Stereotyping* is when labelled differences are linked to stereotypes which are deemed by others to be undesirable. *Separation* occurs when labelled people are placed in distinct categories so as to accomplish some degree of separation between "us" and "them". *Status loss and discrimination* occur when stigma interferes with an individual's ability to participate fully in the social and economic life of her/his community. When individuals lose status or are discriminated against because of their negatively evaluated differences, they experience enacted stigma.

There are a number of misconceptions about people who are suffering from a mental illness, and this "public stigma" (i.e. negative views of mentally ill persons by others) has been well established in the literature. Numerous surveys of community attitudes towards the mentally ill in various countries and population settings have reported generally negative attitudes, which appear to be consistent over time (Green et al., 1987; Mbanga et al., 2002; Taylor & Dear, 1981; Wolf, Soumitra, Craig, & Leff, 1996). Compared to an average person, those with a mental condition (including ex-mental patients) are often viewed as being unpredictable, tense and dangerous, worthless, delicate, slow, weak, dirty, and foolish (Mbanga et al., 2002).

One of the causes for the distorted beliefs about mental illness is the media. It is often reported that characters on television and in the movies suffering from a mental disorder are depicted as dangerous, unpredictable and violent. Derogatory references regarding people with mental illness appear commonly in print, broadcast and cinematographic media (Wahl, 1995). However, it is in children's animation that the highest rate of mental illness being depicted in a negative light can be found. According to a study conducted in New Zealand that used a sample of 1 week of children's television from 2 channels (46 children's programs), of the 128 episodes analysed, 46.1% contained at least one reference to mental illness. The most common terms used to describe an individual with mental illness were "crazy", "mad and losing your mind", which are all negative, and stigmatizing (Wilson, Nairn, Coverdale, & Panapa, 2000). Furthermore, a study conducted in Canada examined Disney animated films for children and found that 85% contained verbal references to mental illness and that they were mainly used to 'set apart and denigrate' the characters (Lawson & Fouts, 2004).

However, only in a relatively small proportion of severe mentally ill patients is violence a concern. For the most part, the public over-estimate the risk due to media reports and dramatic portrayals of mental ill patients (Link et., 1999). This association between mental illness and violence may be increasing. Phelan, Link, Stueve, and Pescosolido (2000) compared the publics' opinion pertaining to mental illness and violence in 1950 and 1996 in the United Sates. Results indicated that the proportion of respondents who described mentally ill patients as violent increased by almost 2-1/2 times between 1950 and 1996 (13%-31%). Furthermore, a number of studies have shown that individuals suffering with a severe psychiatric disorder, who are not receiving treatment (or proper treatment) are more likely than the general population to show signs of violence (Aranga, Calcedo Barba, González-Salvador, & Calcedo Ordóñez, 1999; Kasper, Hoge, & Feucht-Haviar, 1997; Link, Andrews & Cullen, 1992; Modestin & Ammann, 1996; Taylor, 1985; Taylor et al., 1998), though this link is relatively weak. The literature suggests that only a small subgroup of people with severe and persistent mental illness is at risk of becoming violent. However, with treatment and taking prescribed medication, these people are no more dangerous than the general population.

Due to this public stigma, life opportunities such as employment, suitable accommodation and satisfactory health care of the mentally ill may be negatively affected (Farina & Felner, 1973; Bordieri & Drehmer, 1986). A study examining the hiring recommendations of 108 supervisors and managers of disabled job applicants was examined through a survey method. Results indicated that the applicant with paraplegia was more favourably evaluated than the applicant with a history of drug dependence (Bordieri & Drehmer, 1986). Even the general healthcare system has been found to discriminate against those with a mental illness. This is revealed in a study conducted by Druss, Bradford, Rosenheck, Radford, & Krumholz (2000) who reported that individuals with a mental disorder were significantly less likely to get cardiac care compared with the control group not labelled with a mental illness. Furthermore, a study surveying family members of children suffering from a mental illness reported that 75% believed stigma decreased their children's self-esteem, hindered their ability to make friends and limited their success in obtaining employment (Wahl & Harman, 1989).

More recently, studies investigating the personal experiences of stigma of people with a mental disorder (self stigma) are emerging in the literature (e.g. Dinos, Stevens, Serfaty, Weich, King, 2004; Watson, Corrigan, Larson & Sells, 2007). Ritscher, Otilingam, & Grajales (2003) developed a tool specifically aimed to aid clinicians in addressing the effects

of stigma as perceived by patients, called the Stigma of Mental Illness Scale. A modified version of this scale was used in a study conducted in South Africa investigating the experience of internalized stigma in 100 schizophrenic patients using a modified version of the Stigma of Mental Illness Scale (ISMI). Results indicated that 65% of the respondents reported that they felt discriminated against. Sixty percent believed that people with a psychiatric disorder are dangerous, while an appalling 58% reported that they been victims of verbal abuse and 39% of physical abuse. The authors note that the topic of perceived dangerousness of mentally ill individuals is reported frequently in the literature, yet it appears that it may be the mentally ill who are receiving the abusive treatment (Botha, Koen, & Kiehaus, 2006). It is imperative that continued funding and greater development of community-based public mental health services are a top priority in order to reduce the numbers of persons with mental illness who become victims of violence as well as the small subset who are at increased risk of violent behaviour.

Additionally, some research has suggested that the more an individual experiences "self stigmatization", the lower their self-esteem (Herman, 1993; Wahl, 1999). For example, a study investigating whether stigma affects the self-esteem of individuals with a serious mental illness randomly assigned 70 individuals with a mental disorder to 1 of 2 conditions: (1) an intervention aimed to facilitate coping with stigma and (2) a no- intervention control group. Measures of 2 constructs of stigma (devaluation discrimination and stigma withdrawal) and self-esteem were assessed at baseline, and after 6 months and 24 months following the intervention. Results indicated that baseline measures of perceived devaluation-discrimination and stigma-withdrawal strongly predicted low self-esteem at both the six- and the 24-month follow-up (Link, Struening, Neese-Tood, Asmussen, & Phelan, 2001). However, results on the effects of stigma on self-esteem are not conclusive. It is difficult to separate the effects of stigma from other aspects of the illness such as loss of roles and independence. Lowered self-esteem may be an antecedent or symptom of having a mental illness (Brown, Andrews, Bifulco, & Veiel, 1990) or may be the result of grief associated with the loss of cognitive or social functioning (Appelo, Sloof, Woonings, Carson, & Louwerens, 1993).

The literature also reveals that mentally ill patients who "self stigmatize" struggle to adjust socially (Perlick et al., 2001) and often report a lower satisfaction with life (Rosenfield, 1997), than individuals without a mental illness. For example, 264 participants who were admitted as psychiatric inpatients or outpatients and who met the diagnostic criteria for Bipolar Affective Disorder were surveyed on a number of measures, including perceived

stigma, devaluation and discrimination. Social adjustment was measured at baseline and seven months later with the Social Adjustment Scale (SAS). Results indicated that patients with strong concerns about stigma at baseline showed greater impairment in their subsequent social and leisure functioning. Moreover, Rosenfield (1997) compared the importance of perceived stigma versus receiving psychiatric treatment when assessing the quality of life of people who are suffering from a chronic mental illness. Interviews with 157 psychiatric patients that have attended a "club program" (program that provides a number of rehabilitation services) were conducted to evaluate perceived stigma, mutual empowerment, quality of life, self-esteem and access to psychiatric services. Results indicated that a high perceived stigma was associated with low quality of life, and high receipt of services was associated with high quality of life.

Therefore, stigma may also prevent some from seeking professional help (Robertson & Donnermeyer, 1997) and render others less likely to adhere to treatment (Sirey et al., 2001). According to Corrigan and Matthews (2003), stigma has the potential to lead to label avoidance. For example, people with a concealable stigma (gay, HIV+, mentally ill) are aware that if they "come out of the closet" they will then be discriminated against by the public. Therefore, one of the obvious ways not to be linked to other mental patients is not to go where they are receiving care and to avoid the institutions that mark them. Evidence of the link between stigma and low rates of health-seeking is revealed in an epidemiologic survey on 4838 participants. Participants were diagnosed using a diagnostic interview schedule and subsequently asked questions concerning their tendency to utilize mental health services, their perceptions of barriers to accessing services, and the potential reactions of family members to their receiving mental health treatment. Results indicated that participants were less likely to use services if they expected negative reactions of family members (Leaf, Bruce, & Tischler, 1986). Although evidence suggests there is a link between stigma and service use, further research is required. Sirey et al., (2001) interviewed 134 patients diagnosed with major depression who were seeking treatment from 6 outpatient clinics in New York. The study investigated perceived stigma, self-rated severity of illness, and views about treatment. Results indicated that adherence to treatment was associated with lower reports of perceived stigma, higher reports of self-rated severity of illness, and being over 60 years of age (Sirey et al., 2001).

Furthermore, the mentally ill are often confronted with prejudice and discrimination as a result of various policies and practices. This is referred to in the literature as structural

stigma. These include disparities in medical aid coverage, employment opportunities, and access to health care resources. Limited health care resources are due to the low priority and funding that psychiatry receives worldwide, both on a national and policy level. For example, a nationally representative survey including 116 179 participants assessed the association between having a mental disorder, access to health insurance, and actually receiving medical care. Results indicated that there was no difference in the likelihood of being insured between those with a disorder and those without. However, individuals with a mental disorder were more likely to report a difficulty in procuring health insurance, which consequently increased the likelihood of this group of individuals having concern over keeping their jobs, in fear of losing their medical benefits (Druss & Rosenheck, 1998). These results depict mental illness as a barrier to receiving appropriate care in addition to being an obstacle in achieving mental health parity.

A number of organizations, including advocacy groups and various government organizations, rely on a range of strategies to diminish the impact of stigma. Three main strategies for combating stigma have been suggested in the literature: protest, education, and contact (Corrigan & Penn, 1999). To begin with, the **protest** discourages the media from incorrectly representing mental illness and perpetuating negative stereotypes. Secondly, **education** programmes involve providing accurate facts and information about mental illness to facilitate informed decision-making. There are a number of different methods of education when it comes to mental illness, such as books, videos, and structured teaching programmes. Brief educational courses on mental illness have proved to reduce stigmatizing attitudes among a wide variety of participants. However, when programs address the concept of mental health literacy, the message and the method of education must be customized for the varying different diagnoses and groups for which the intervention is intended. For example, the stigma associated with schizophrenic patients is that they are dangerous and unpredictable, while having a weak character is associated with individuals suffering from a substance use disorders. However, research suggests that the methods of protest and education might lead to mild changes in attitude and limited behaviour change (Holmes, Corrigan, Williams, Canar, & Kubiak, 1999). A literature review by Corrigan and Penn (1999), found that studies implementing the protest strategy generally did not have a significant effect on stigmatizing attitudes, but studies assessing the education strategy have been met with moderate success. The type of information provided to participants seems to be important for affecting attitudes, although the effects may not be very robust (i.e., the durability of the effects may be limited).

Contact, an intervention method that challenges public attitudes concerning mental illness through direct contact with people who have a mental disorder, appears to be the most promising strategy for reducing psychiatric stigma (Corrigan & Penn, 1999). A study conducted by Reinke, Corrigan, Leonhard, Lundin, & Kubiak (2004), randomly assigned college students to 1 of 5 groups. These groups represented "high contact" 'which refers to meeting a person who would challenge the stereotypes significantly (i.e. celebrity), 'low contact' which refers to meeting a person who significantly mirrors the stereotypes of someone with a mental illness (i.e. homeless person) and "middle contact" which refers to someone who is struggling with a mental illness, but nevertheless is working full time and living independently. The five groups included: (a) face to face "middle contact" contact; (b) videotaped "middle contact"; (c) videotaped "high contact"; (d) videotaped "low contact"; and (e) a no-stigma change control group. Attitudes were measured pre-contact, post-contact, and at follow-up. Results indicated that "low contact" did not significantly challenge a stereotype, while "high contact" had an effect of challenging a stereotype, but this effect was minimal. However, "middle contact" significantly challenged the stereotype, therefore when an individual encounters a neighbour, a co-worker or something from church, stereotypes are more likely to be challenged.

A number of celebrities have spoken out about their experiences with combating a mental illness (high contact). For example, John Forbes Nash Jr. the Nobel Prize-winning economist spoke out about his illness (schizophrenia), and consequently a movie was produced depicting his life. Other examples include Patty Duke (bipolar disorder), Lorraine Bracco (depression) and Brooke Shields (postpartum depression). Thus "high contact" has shown some potential in challenging stereotypes. It is believed that celebrities who openly discuss their struggles with mental illness may increase public awareness and help make it easier for others to disclose their struggles with the illness.

In summary, although not rigorously evaluated in South Africa, there is some evidence of low mental health literacy and the potential for relatively high levels of stigmatization. The next section will focus on mental health advocacy groups located specifically in South Africa and how they may contribute to mental health care in the country.

2.8.6 Mental Health Advocacy Groups in South Africa

Unlike the rest of sub-Saharan Africa, in South Africa there has been a development of a range of strong and dynamic consumer groups focussing on a wide range of psychiatric disorders (Stein & Emsley, 1998). Although there are a number of organizations of various sizes that play valuable roles in the area of mental health advocacy, not all will be described in this section. A few of the advocacy groups presently active in South Africa are the South African Federation for Mental Health, Post Natal Depression Support Group Association (PNDSA), Alzheimer's SA, Mental Health Information Centre (MHIC) and the South African Depression & Anxiety Group (SADAG). The work of the SADAG will be described in more detail.

The South African Depression & Anxiety Group (SADAG)

SADAG was initiated by consumers in 1995 and has rapidly grown over the past 12 years. The group has been at the forefront of providing counselling services, mental health awareness programs, powerful media campaigns, school talks and rural outreach initiatives to thousands of patients, families and communities in South Africa. In addition, SADAG has initiated over 120 support groups nationwide, and has an extensive referral guide reaching into the most remote regions of South Africa. Trained counsellors operate the Mental Health Counselling Centre and the toll free Suicide Crisis Line everyday from 8am to 8pm (South African Depression & Anxiety Group, 2008).

Since 1997, SADAG has initiated rural development projects in communities where there are little or no mental health care services available. The group provides workshops for a variety of community members, including home based care workers (HBCWs), educators, police, students, youth workers and traditional healers. Over the past 4 years SADAG has made efforts to increase the mental health literacy of traditional healers in a 3-4 hour educational workshop. The aims of this workshop are to:

- educate traditional healers on the concept of mental illness;
- educate traditional healers on the signs and symptoms of depression;
- provide information to traditional healers on psychiatric treatments available to help people suffering from depression; and

- encourage traditional healers to refer their mentally ill patients to a Western doctor if they are not responding to traditional treatment.

However, one of the main concerns NGO's are now facing is the importance of evaluating the effectiveness of programs when the outcomes of interest include constructs such as attitudes and behaviour change. Not to mention whether they actually have any effect on treatment. This is a challenge as constructs such as behaviour and attitude can be difficult to measure. However, social cognitive models may contribute to the understanding of behaviours such as traditional healer referral in the mental health area. They may also be useful in understanding how behaviour change occurs and in interventions to promote change.

2.9 Social Cognitive Models and the Theory of Planned Behaviour (TPB)

The following section will focus on the importance of social cognitive models in designing interventions and assessing behaviour change. The Theory of Planned Behaviour will be discussed in detail, in addition to the way the theory can be used to predict traditional healer referral of mentally ill patients to Western practitioners.

2.9.1 Theory of Planned Behaviour (TPB)

Several social cognitive models have been developed in order to understand and predict people's health behaviours. These prominent models include the Health Belief Model (Bandura, 1977), Protection Motivation Theory (Rogers, 1975), Transtheoretical models (Prochaska & Velicer, 1997) and the Theory of Planned Behaviour (Ajzen, 1991).

The Theory of Planned Behaviour (TPB) is one of the most thoroughly tested and robust of the social cognitive models (Ajzen, 1991). This is just one of the reasons why this theoretical framework was selected for this particular study. In addition, a number of reviews and empirical comparisons have demonstrated that the theories of reasoned action and planned behaviour have superior predictive power when compared with other models of health behaviour (e.g., Armitage & Conner, 2001; Quine, Rutter, & Arnold, 1998), because of its apparent ability to predict and explain human behaviour. Furthermore, given the obvious significance of attitudinal factors when addressing the concept of referral, the TPB may be a useful theoretical framework to address this issue. The next section will describe the TPB in more detail.

The Theory of Planned Behaviour (TPB; see Figure 3) proposed by Ajzen, (1988, 1991) is an expectancy-value model that has had a major impact on research concerned with the prediction of intention and behaviour, particularly health behaviour (Rutter, 2000). Developed from the Theory of Reasoned Action (TRA), the TPB posits that behavioural intention is regarded as the proximal determinant of behaviour. Behavioural intention is regarded as the motivation necessary to engage in a particular behaviour: the greater one's intention to (for example to refer a patient), the more likely one is to actually engage in this act. Consequently, behavioural intentions are a function of three constructs: (a) attitude toward behaviour; (b) subjective norms of behaviour; and (c) perceived behavioural control (Ajzen, 1991).

'Attitude' is an individual's positive or negative belief about performing a specific behaviour, and is determined by the individual's beliefs about the consequences of performing the behaviour (behavioural beliefs), weighted by his or her evaluation of those consequences (outcome evaluations) (Ajzen, 1991). Therefore, a person is more likely to change their behaviour if he or she has a positive attitude toward the behaviour. Subjective norms are a function of whether or not certain individuals around them would approve or disapprove of the behaviour. According to the TPB, beliefs that underlie subjective norms are termed 'normative beliefs'. It is thought that an individual will intend to perform a behaviour when he/ she perceives that important others in their life think they should engage in that particular behaviour. These important people may include a member of a person's family, their friends, or their traditional healer or Western doctor. Perceived behavioural control refers to a persons' perception of the ease or difficulty of performing the behaviour of interest. The more favourable the attitude and subjective norm with respect to the behaviour and the greater the perceived behavioural control, the stronger the individual's intention will be to perform the behaviour under consideration.

These three constructs may be measured either directly (e.g. by asking people to report whether their attitude to the behaviour is favourable or unfavourable) or indirectly (by asking people about specific beliefs and then combining the scores according to theoretical principles to infer whether the attitude is favourable or unfavourable). Ajzen (2002) argues that both indirect and direct types of measures serve as indicators of the underlying construct. However, this does not imply that the indirect measure of attitudes (attitude beliefs) operate as determinants of direct measures. Instead, the beliefs are the determinants of the attitude, which can be measured directly. This relation between beliefs, direct measures, and the

underlying construct is similar for subjective norms, and perceived behavioural control. Given this relation, it is expected that the two types of measures should be correlated.

The TPB can be considered a successful model of the attitude-behaviour relationship, because of its apparent ability to predict and explain human behaviour in various content domains. The TPB has been applied to the prediction of a number of different health behaviours with varying degrees of success (Ajzen, 1991; Conner & Sparks, 1996). For example, the health behaviours studied include: smoking (Godin, Valois, Lepage, & Desharnais, 1992), drinking alcohol (Schlegel, D'avernas, Zanna, Decourville, & Manske, 1992), condom use (Wilson, Zenda, McMaster, & Lavelle, 1992), health screening attendance (Norman & Conner, 1996), exercise (Norman & Smith, 1995), just to name a few. Furthermore, the TPB has been shown to be applicable in African populations (Aarø et al., 2006; Panday, Reddy, & Ruiter, 2007).

There is substantial evidence supporting the predictive validity of the TPB model. A meta-analysis (Armitage & Conner, 2001) of 185 independent studies (published until 1997) found an average correlation of 0.63 for attitude, Subjective Norm and Perceived Behaviour Control with intention and an average correlation of 0.47 between intention and behaviour. Similarly, Godin and Kok (1996) found that the TPB can account for 41% of the variance in intention and 34% of the variance in behaviour.

However, there is a great deal of debate in the literature addressing the actual applicability of the TPB with regard to intention being the antecedent of behaviour. Studies that investigated the robustness of the intention-behaviour relationship indicate that a significant gap exists between behavioural intention and behaviour (Albarracin, Johnson, Fishbein, & Muellerleile, 2001), often being referred to as the "Intention Behaviour Gap". Further understanding of the role of intention as an antecedent to behaviour is essential. Therefore, in spite of broad support for the TPB, it has been argued that it might be possible to increase the predictive power of the model by incorporating additional variables (Conner & Armitage, 1998).

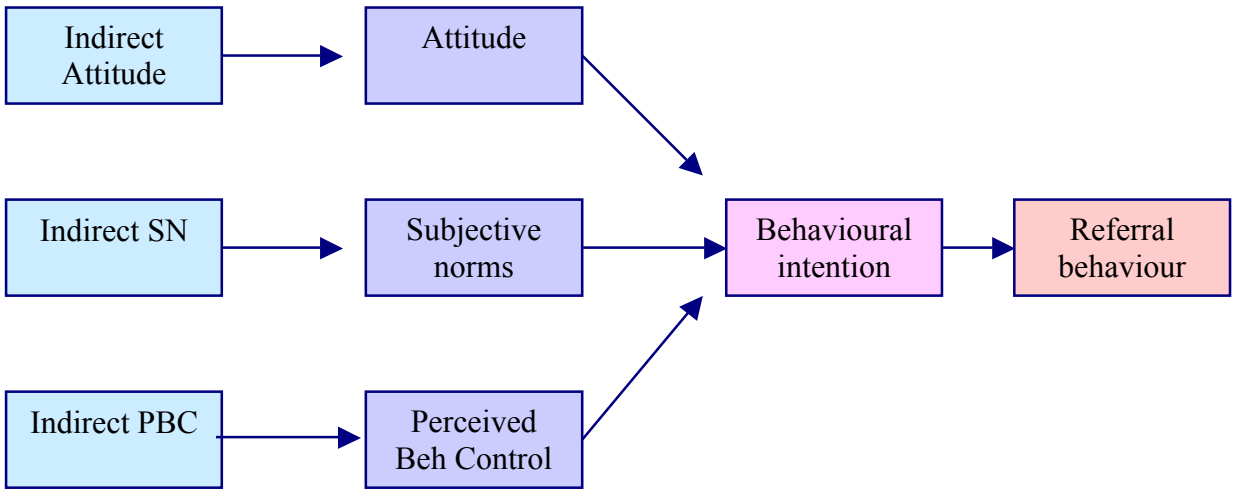
For example, some researchers have argued for the inclusion of past behaviour in the model (Sutton, 1994). There are two key viewpoints with regards to the effect of past behaviour on present behaviour – particularly in the context of TPB. One view presented by researchers argues that many health behaviours are determined by past behaviour – not the effects of cognitions described in the TPB (Sutton, 1994). Their evidence suggests that past behaviour is directly associated with behavioural intentions (Bagozzi, Baumgartner, & Yi, 1992). These

results support claims for the inclusion of past behaviour as an independent predictor of behaviour and behavioural intentions in the TPB model (Conner, Warren, Close, & Sparks, 1999).

Conversely, Azjen (1991) highlights the core problems with this by reporting three studies where the amount of variance added to the prediction of behaviour by past behaviour was extremely small (2.1%). This small variance can be explained as a common method variance from the use of similar response formats for the two measures. Additionally, the effects of past behaviours commonly result from habituation when behaviour has been previously performed (Conner & Harmitage, 1998). As the controversy is ongoing, more research is needed to determine the extent to which past behaviour may impact on intention and future behaviours. (Conner et al., 1999)

In addition, in an attempt to fill this intention-behaviour gap, previous studies have included constructs from Bandura's Social Cognitive Theory (Bandura, 1977) as moderators between intention and behaviour (eg. Aarø et al, 2006). These constructs included skills/knowledge and environmental conditions (barriers). Social Cognitive Theory provides a broad variety of theoretical constructs that are associated with behaviour and behaviour change, but basically involves the reciprocal relationships among cognition/personal, behaviours, and the environment. These are interdependent causal factors, but each has the capacity to affect the others in reciprocal relationships. The triadic reciprocal relationship is called reciprocal determinism. While Social Cognitive Theory upholds the behaviourist notion that response consequences mediate behaviour, it contends that behaviour is mainly regulated through antecedent cognitive processes.

Figure 1: Theory of Planned Behaviour



2.9.2 TPB and the Referral Practices of Health Care Professionals

The TPB has been widely used to explore factors associated with health professionals' beliefs and attitudes to health-related behaviour (Limbert & Lamb, 2002; McCarty, Hennrikus, Lando, Vessey, 2001; Walker, Grimishaw, & Armstrong, 2001). Similar factors may influence traditional healers' decision to refer their mentally ill patients to a Western doctor. However, only a few studies have utilized the TPB to address the practice of referral of health care professionals. For example, a study conducted by Conner & Heywood-Everett (1998), examined the decision of general practitioners to refer their Asian and non-Asian patients to mental health care services and the factors that might influence this decision. Results indicated that GPs were more likely to intend to refer non-Asian patients to mental health services and the study provides evidence that the TPB may contribute to the understanding of behaviours such as referral in the mental health area. However, the results of this study were somewhat limited, as the construct of behaviour was not measured. Another study utilized the TRA and TPB to predict physicians' behaviour in regard to educating adolescent patients about STD's with a focus on HIV and AIDS. Although the main purpose of this study was to compare the two theories in predicting behaviour (results indicated TPB was superior), the study revealed that the TPB has relevance for predicting the behaviour of health care professionals (Millstein, 1996).

Presently we are not aware of any attempts to utilize the TPB to gain a better understanding of traditional healers and their decision to refer their patients to a Western practitioner. Chapter 7 addresses this gap by answering the following question:

What are the beliefs and attitudes associated with traditional healers and their decision to refer adolescents and adults suffering from a mental illness to a Western practitioner?

2.10 Conclusion

The purpose of this chapter was to review the literature relating to the main research objectives derived in Chapter 1. Gaps in the available literature were revealed and details of how the present study will attempt to fill these gaps were described. The next chapter will look at the first question proposed in Chapter 1, to what extent do patients suffering from a mental illness in South Africa consult traditional healers for their emotional and mental health care concerns.

CHAPTER 3

THE EXTENT TRADITIONAL HEALERS ARE CONSULTED FOR NON-PSYCHOTIC MENTAL HEALTH DISORDERS IN SOUTH AFRICA

3.1 Background

The first research question proposed in Chapter One, was to examine the extent patients suffering from a mental illness in South Africa consult traditional healers for their emotional and mental health care concerns. The Literature review (Chapter 2) provides more detail on this topic on page 16. A brief summary follows.

Results from the South African Stress and Health Study, the first nationally-representative study of psychiatric morbidity in South Africa, indicate that approximately 30% of adults have experienced a DSM-IV disorder in their lifetime; this includes 16% with an anxiety disorder, 10% with a mood disorder and 13% with a substance use disorder (Stein et al., 2008). Most South Africans have limited access to psychiatric care. One national study reported that the overall staff/population ratio in the public sector mental health services was 19.5 per 100,000 of the population, with an inter- provincial range of 5.7-31.5 per 100,000 (Lund & Flisher, 2002). SASH found that only one-quarter of South Africans with a recent DSM-IV diagnosis received treatment in the year preceding the interview (Wang et al., 2007).

Results of small studies conducted in South Africa investigating individuals with a mental illness report that approximately one-half (41-61%) of patients have consulted a traditional healer (Freeman et al., 1994; Ensink & Robertson, 1999). These studies were described in detail in Chapter Two. Additionally, although there is a gap in the literature on predicting traditional healer use in South Africa, studies conducted in Zimbabwe and Tanzania result in conflicting findings. In Tanzania, multivariate analysis indicated that being better educated, older, widowed or separated and being of Christian faith were independently associated with consulting a traditional healer (Ngoma & Prince, 2003). In Zimbabwe, a different pattern emerged, in that patients of traditional healers were more likely to be female and also to be unemployed, with less education (Patel et al., 1997).

However, these have been small studies employing a range of convenience sampling methods, leading to results that are difficult to generalise to the South African population as a whole. In

turn, the extent to which alternative practioners are consulted, and predictors of traditional healer visits, remains poorly understood. This study used the SASH dataset was used to examine the use of alternative practitioners for mental health concerns among the South African population.

3.2 Methods

The South African Stress and Health (SASH) study (Williams, Herman, Kessler, Sonnega, Seedat, & Stein, 2004), was undertaken as part of the World Mental Health Survey (Demyttenaere et al., 2004) to investigate the prevalence of mental disorders in the South African context. The survey was conducted between January 2002 and June 2004. The rationale and survey methods have been detailed previously (Williams et al., 2004) and are briefly summarized here. Ethical approval was provided by the University of Michigan, Harvard Medical School and by a single project assurance of compliance from the Medical University of South Africa that was approved by the National Institute of Mental Health.

3.2.1 Sample Selection

The study population consisted of South Africans who resided in both households and hostels and were a minimum of 18 years old. The sample excluded those individuals living in institutions (including hospitals, prisons, mental health institutions and military bases). The sample was selected using a multi-stage area probability sample design. First, Enumerator Areas (EA; a unit of census administration) used in the 2001 national census were stratified according to province, location (rural/urban) and majority population group (African, coloured, white or Indian); 960 EAs were selected from the resulting strata, with the number of EAs selected per stratum proportional to the estimated stratum population (minimum, 1; maximum, 85). Second, within each EA a random sample of 5 households was selected and finally the third stage consisted of a random sub-selection of a single adult respondent in each selected sample housing unit.

Up to three attempts were made to contact each respondent selected to participate. The overall response rate was 85% and the final sample consisted of 3651 individuals. The SASH interviewers received intensive training for one week in centralized group sessions. The face-to-face interviews lasted approximately three and a half hours, although a number of interviews required more than one visit to complete. The interviews were conducted in one of six languages: English, Afrikaans, Zulu, Xhosa, Northern Sotho, and Tswana.

3.2.2 Measures

Participant demographic characteristic were collected using standard questionnaire items. It is noteworthy to disclose that race was assessed using the race groups as defined by the apartheid government (Asian, black, coloured, white), as these categories are still relevant in terms of health outcomes. In this context 'black' refers to not being coloured, white or Indian/Asian, while the term 'coloured' refers to an ethnic group of people who possess some degree of sub-Saharan ancestry, but not enough to be considered Black during apartheid. Additionally, income was divided into categories of R1-5000 (US$1-$714), R5001-25 000 (US$714- $3 571), 25 000-100 000 (US$ 571-$14 285), R 100 000+ (US$ 14 285+).

A modified version of the World Mental Health Composite International Diagnostic Interview (WMH-CIDI) was used to assess lifetime DSM-IV disorders and treatment. The lifetime DSM-IV disorders included: anxiety disorders (panic disorder, agoraphobia, social phobia, generalized anxiety disorder and posttraumatic stress disorder), mood disorders (major depressive disorder, dysthmia), substance use disorders (alcohol and drug abuse and dependence), and disorders associated with impulse control (intermittent explosive disorder). In addition, the lifetime experience of trauma was measured.

The mental health service utilization module of the questionnaire assessed participants treatment received in the past 12 months for problems associated with "emotions or mental health". The list of treatment providers included a (1) psychiatrist; (2) other mental health professional (e.g., psychologist, psychotherapist, psychiatric social worker, mental health nurse, mental health counsellor); (3) a general practitioner or other medical doctor; (4) any other health professional (e.g., nurse or physician's assistant) (5) traditional healer; (6) religious or spiritual advisor (e.g., minister, priest, or rabbi); (7) any other healer (e.g., chiropractor or spiritualist). For the purpose of this study mental health service utilization was grouped into the following categories:

- *Western Medicine*: Psychiatrist, other mental health professionals (psychologist, psychotherapist, psychiatric social worker, a mental health nurse or mental health counsellor), a general practitioner or any other medical doctor, any other health professional, such as a nurse or physician's assistant.

- *Alternative Medicine:* Traditional healer, spiritual or religious advisor (e.g., minister, priest, or rabbi), or any other healer (e.g., chiropractor or spiritualist).

3.3.3 Data Management & Analysis

Data were analysed using Stata Version 9.0 (College Station, Texas, USA). All analyses were weighted to adjust for sample selection, non-response, and for residual discrepancies between the sample and the population on a profile of Census demographic and geographic variables. We examined the unadjusted associations between service use as the dependent variable, and lifetime DSM-IV diagnosis (any versus none) and participant demographic characteristics as independent variables. Pearson's chi-squared test was used for the comparison of proportions and a corrected t-test was used to compare means. Statistical significance was based on 2-sided tests set at α=0.05. In addition, we developed three multiple logistic regression models of whether a traditional healer was consulted for emotional and mental health concerns on demographic variables. The first model was based on the full sample, the second model on participants with a lifetime DSM-IV diagnosis, and the third model on those with no lifetime DSM-IV diagnosis. The results of the regression models were reported as odds ratios (ORs) with 95% confidence intervals (CIs).

3.3 Results

3.3.1 Characteristics of Sample

The 3651 respondents had a mean age of 37 years; 46% were male; and 76% were black, 10% coloured, 3% Indian/Asian and 10% white (Table 3.1). A majority of the participants lived in an urban area (62% vs. 38%). Only 40% of the respondents had more than a high school education, 51% were married and 31% were employed.

Of the total sample, 32% had a lifetime DSM-IV disorder. Overall 28% of the total sample reported seeking treatment during the last 12 months; 39% and 23% of those with and with no lifetime DSM-IV disorder respectively reported seeking treatment during the last 12 months. The prevalence of seeking treatment was similar among those with anxiety (41%), mood (40%) and substance use disorders (41%), respectively.

Table 3.1 Description of participant demographic characteristics, mental health seeking behaviours and DSM-IV diagnosis in a nationally representative sample of South African adults (N = 3651)

	Total Sample % N= 3651	**Individuals with any DSM-IV disorder (%)**	**Individuals with no DSM-IV disorder(%)**
Age: 18-29	39.1	36.5	40.3
30-39	22.1	23.3	21.5
40-49	18.1	20.8	16.8
50+	20.7	19.3	21.4
Sex: Male	46.3	47.4	45.8
Race: Black	76.2	75.2	76.7
Coloured	10.4	12.0	9.7
White	10.0	9.7	10.1
Indian/Asian	3.4	3.2	3.5
Currently married	50.1	49.7	50.3
Location: Rural	38.4	35.8	39.6
Urban	61.6	64.2	60.4
Employed: Yes	31.0	33.9	29.7
No	69.0	66.1	70.3
Education: 0-Gr12	59.7	59.2	59.9
High school +	40.3	40.8	40.1
Traumatic Life events (0)	35.0	24.8	39.9
1-2	39.5	40.6	39.1
3-4	17.3	22.6	14.8
25+	8.1	12.0	6.3
DSM-IV diagnoses			
Any Disorder	31.9	100.0	-
Any Anxiety Disorders	16.1	50.5	-
Any Mood Disorder	11.9	37.1	-
Any Substance Disorder	13.3	41.6	-
Mental health seeking			
No form of health care	72.2	61.5	77.3
Any form of health care*	27.8	38.5	22.7
Western Medicine □	21.1	28.9	17.5
Alternative Medicine □	13.1	19.9	9.9
Western & Alternative ¤	7.0	11.3	4.9
Traditional Healer	6.4	8.9	5.2

**Any use*- speaking with a professional about problems with emotions or mental health

□*Western Medicine* – psychiatrist, other mental health professional, such as a psychologist, psychotherapist, psychiatric social worker, a mental health nurse or mental health counsellor, a general practitioner or any other medical doctor, any other health professional, like a nurse of physician's assistant

□*Alternative Medicine* – a traditional healer, a religious or spiritual advisor like a minister, priest or rabbi, and any other healer

¤*Western & Alternative*– at least one western and one alternative

Relying solely on self-reported measures, the average number of visits for mental health care in the past 12 months was 2.7 for traditional healers, and 3.4 for Western medical practitioners (Table 3.2). The mean duration of each visit was 43 minutes for a consultation with a traditional healer, and 32 minutes for a Western medical practitioner. The average costs in the last 12 months were R321 and R318 for consulting a traditional healer and Western health practitioner respectively.

Table 3.2 Comparison of Western practitioners and traditional healer consultations

	Traditional healer (n=57)	Western Medicine (n=26)
Mean # of visits	2.7	3.4
Average duration of visits (minutes)	42.7	32.2
Average cost spent in the past 12 months (Rand)	321.08	318.31

3.3.2 Health seeking behaviour in the full sample

Of the 28% of participants who sought treatment (regardless of whether they met lifetime DSM-IV criteria for a disorder or not), 21% were treated by Western practitioners, 13% were treated by alternative practitioners, and 7% by a combination of both Western and alternative practitioners. Similar proportions were reported in participants with and without a common mental disorder (Table 3.3). Of the subjects who sought treatment from alternative medicine, 6% sought treatment from a traditional healer, 7% of the sample sought treatment from a spiritual or religious advisor, and 2% by another type of healer. However, while 14% of respondents sought treatment from a Western practitioner exclusively, only 2% sought treatment from a traditional healer exclusively (see Table 3.3).

Table 3.3 Comparison of types of alternative medicine practitioners in a nationally representative sample of South African adults

Type of Practitioner	Total Sample	With DSM-IV Diagnosis	Without DSM-IV Diagnosis
Traditional healer	6.4	8.9	5.2
Religious or spiritual advisor	6.9	10.8	5.1
Chiropractor or spiritualist	2.2	3.2	1.8
Traditional healer exclusively	2.4	3.6	1.9

Being above 40 years of age and having a 12 month DSM-IV diagnosis (OR=2.3, 95% CI 1.8-2.9) was associated with seeking help from alternative practitioners (Table 3.4). Traditional healer use in the full sample was associated with age, black race, employment, having less than a grade education, (OR=0.5, 95% CI 0.3-0.7), experiencing a traumatic event, and having an anxiety or a substance use disorder (OR=1.8, 95% CI 1.3-2.4). Ninety seven percent of participants' who consulted a traditional healer were black.

Table 3.4 Unadjusted associations between mental health seeking behaviour and participant demographic characteristics overall and the presence or absence of DSM-IV defined mental disorder, in a nationally representative sample of South African adults.

	No health Care	Western Medicine	OR (95% CI)	Alternative Medicine	OR (95% CI)	Western & Alternative	OR (95% CI)	Traditional Healer	OR (95% CI)
Age (mean)	36.1	39.7		39.4		41.0		40.0	
18-29	42.2	29.3	1.0	30.4	1.0	24.9	1.0	28.9	1.0
30-39	21.7	22.6	1.5 (1.2-1.8)	23.4	1.4 (1.0-2.0)	23.8	1.8 (1.2-2.6)	22.3	1.4 (0.9-2.2)
40-49	17.1	21.9	1.8 (1.4-2.4)	21.7	1.5 (1.3-2.1)	25.3	2.3 (1.7-3.3)	21.1	1.6 (1.0-2.6)
50+	19.0	26.3	1.9 (1.4-2.6)	24.5	1.6 (1.3-2.0)	26.0	2.1 (1.4-3.0)	27.6	1.9 (1.3-2.6)
Sex: Male	47.8	44.3	1.0	41.0	1.0	44.4	1.0	45.1	1.0
Female	52.3	55.7	1.1 (0.9-1.4)	59.0	1.3 (1.0-1.7)	55.6	1.1 (0.9-1.4)	55.0	1.1 (0.7-1.5)
Race: Black	76.0	73.3	1.0	86.7	1.0	83.4	1.0	96.6	1.0
Coloured	11.1	9.2	0.9 (0.6-1.4)	5.2	0.4 (0.3-0.6)	5.2	0.4 (0.3-0.7)	1.4	0.01 (0.03-0.4)
White	9.8	12.6	1.4 (0.8-2.7)	5.1	0.4 (0.2-1.1)	7.1	0.6 (0.2-1.8)	0.3	0.02 (0.003-0.1)
Indian/Asian	3.1	4.8	1.7 (1.1-2.7)	3.0	0.8 (0.4-1.5)	4.3	1.2 (0.6-2.3)	1.8	0.4 (0.2-0.9)
Currently married	48.4	57.0	1.5 (1.1-1.8)	52.6	1.1 (0.9-1.4)	56.9	1.3 (1.0-1.8)	55.4	1.3 (0.9-1.8)
Rural	38.4	36.0	0.9 (0.7-1.1)	43.3	1.3 (1.0-1.7)	40.2	1.1 (0.8-1.5)	48.5	1.6 (1.1-2.1)
Employed	30.0	33.7	1.2 (0.9-1.5)	33.3	1.1 (0.9-1.4)	34.4	1.2 (0.9-1.6)	34.2	1.2 (0.9-1.5)
High school completed	40.7	41.3	1.1 (0.8-1.4)	33.8	0.7 (0.6-0.9)	36.2	0.8 (0.6-1.2)	25.3	0.5 (0.3-0.7)
Traumatic Life Events									
None	39.2	24.3	1.0	20.4	1.0	18.6	1.0	21.4	1.0
1-2	39.4	39.6	1.6 (1.2-2.0)	28.0	1.7 (1.3-2.4)	24.4	1.7 (1.1-2.6)	36.7	1.6 (1.0-2.3)
3-4	14.9	23.8	2.4 (1.9-3.0)	27.5	3.2 (2.2-4.7)	32.4	3.9 (2.4-6.4)	25.4	2.5 (1.6-4.0)
5 +	6.5	12.2	2.7 (2.0-3.6)	14.2	3.6 (2.5-5.1)	14.7	3.8 (2.2-6.5)	16.5	3.7 (2.6-5.3)
No Disorder	72.8	56.3	1.0	51.4	1.0	48.2	1.0	55.3	1.0
Any Disorder	27.2	43.7	1.9 (1.6-2.3)	48.6	2.3 (1.8-2.9)	51.8	2.5 (1.7-3.5)	44.7	1.8 (1.3-2.4)

After adjusting for the effects of other variables in the model, participants older than 50 years had an increased likelihood of consulting a traditional healer compared to the 18-29 year olds (OR=1.8, 95% CI 1.3-2.7) (Table 3.6). Black respondents were 9.1 times more likely (OR=9.1, 95% 4.4-19.3) (data not shown) to consult traditional healers than white, coloured and Asian respondents. Having completed high school decreased the odds of consulting a traditional healer (OR=0.7, 95% CI 0.5-1.0). Being employed (OR=1.4, 95% CI 1.0-1.8), having a substance abuse disorder (OR=1.69, 95% CI 1.1-2.5) or an anxiety disorder (OR=1.7, 95% CI 1.2-2.4) were associated with consulting a traditional healer for emotional and mental health concerns.

3.3.3 Health seeking behaviour among participants with a DSM-IV diagnosis

Similar findings were apparent in those with a lifetime DSM-IV diagnosis. Overall, 62% reported no treatment in the past 12 months (see table 3.1) and while 18% of respondents sought treatment from a Western practitioner exclusively, only 4% sought treatment from a traditional healer exclusively (Table 3.3). Patients with a DSM-IV disorder who consulted a traditional healer for their emotional and mental health concerns were more likely to be located in an urban setting (OR=2.0, 95% CI 1.3-3.2), be between 40-49 years old and had experienced more than three traumatic events in their lifetime. Patients with more than a grade 12 education (OR=0.42, 95% CI 0.22-0.80) and coloured, whites and Indian/Asians (OR = 0.06, 95% CI 0.01-0.4) were less likely to call upon the services of a traditional healer, while 97% of participants who consulted a traditional healer were black (Table 3.5).

Being between 40-49 years old was independently associated with an increased likelihood of consulted a traditional healer compared to the 18-29 year olds (OR=1.8 95% CI 1.1-3.2) (Table 3.6). Blacks were more likely to consult a traditional healer for emotional and mental health concerns (OR=0.06, 95% CI 0.02-0.3), than whites, Indians and Asians. Although not significant, a higher level of education (grade 12 +) was associated with a 43% decrease in consulting a traditional healer (OR=0.6, 95% CI 0.3-1.1) compared to less educated respondents, and being employed increased the likelihood of consulting a traditional healer for emotional and mental health concerns (OR=1.5, CI 0.9-2.5). Gender, marital status and religion were not associated with traditional healer consultation.

Table 3.5 Unadjusted associations between mental health seeking behaviour and participant demographic characteristics in the presence or absence of a DSM-IV defined mental disorder, in a nationally representative sample of South African adults

	No health Care	Western Medicine	OR (95% CI)	Alternative Medicine	OR (95% CI)	Western & Alternative	OR (95% CI)	Traditional Healer	OR (95% CI)
DSM-IV DIAGNOSIS									
Any anxiety disorder	59.1	30.2	1.1 (0.8-1.5)	19.9	1.3 (1.0-1.8)	11.3	1.3 (0.9-2.0)	8.9	1.4 (1.0-2.1)
Any mood disorder	59.9	30.1	1.1 (0.8-1.5)	21.3	1.1 (0.9-1.5)	12.1	1.1 (0.8-1.6)	8.0	0.8 (0.5-1.3)
Any substance disorder	59.0	32.3	1.3 (1.0-1.8)	21.7	1.2 (0.9-1.6)	13.8	1.5 (1.1-2.1)	9.7	1.2 (0.7-1.9)
Age 18-29	43.0	23.2	1.0	27.8	1.0	23.2	1.0	27.8	1.0
30-39	22.1	26.3	2.15 (1.47-3.14)	23.4	1.40 (0.86-2.28)	25.0	1.79 (0.93-3.45)	21.0	1.20 (0.65-2.22)
40-49	18.9	25.1	2.37 (1.55-3.62)	27.0	1.95 (1.22-3.10)	30.2	2.54 (1.38-4.66)	29.3	1.97 (1.18-3.28)
50+	16.1	26.6	2.74 (1.73-4.35)	21.8	1.62 (1.10-2.38)	21.6	1.87 (1.07-3.29)	21.9	1.54 (0.94-2.55)
Sex: Female	51.0	55.8	1.20 (0.88-1.63)	55.2	1.14 (0.82-1.59)	56.4	1.19 (0.86-1.64)	53.0	1.02 (0.60-1.72)
Race: Black	76.1	69.7	1.0	83.6	1.0	79.8	1.0	97.4	1.0
Coloured	12.0	12.6	1.19 (0.76-1.87)	6.8	0.45 (0.32-0.63)	6.6	0.49 (0.27-0.88)	1.7	0.10 (0.02-0.60)
White	9.0	13.1	1.75 (1.20-2.54)	7.4	0.63 (0.31-1.29)	10.4	1.01 (0.40-2.58)	0.6	0.44 (0.01-0.30)
Indian/Asian	2.8	4.7	2.06 (0.93-2.55)	2.2	0.56 (0.18-1.61)	3.2	0.94 (0.27-3.30)	0.3	0.06 (0.01-0.38)
Currently married	47.0	56.8	1.50 (1.12-2.00)	50.6	1.05 (0.78-1.42)	55.0	1.27 (0.90-1.79)	51.3	1.07 (0.72-1.61)
Location: Rural	34.6	36.9	1.1 (0.8-1.4)	42.1	1.4 (0.9-2.1)	41.6	1.3 (0.8-2.2)	49.0	2.0 (1.3-3.2)
Employed	32.2	35.1	1.1 (0.9-1.5)	36.1	1.1 (0.8-1.5)	33.8	1.0 (0.6-1.6)	27.6	1.2 (0.7-1.9)
Graduated High School	40.9	43.1	1.14 (0.84-1.56)	34.8	0.73 (0.54-0.98)	37.7	0.97 (0.53-1.41)	23.7	0.42 (0.22-0.80)
Traumatic Life Events - None	29.5	17.0	1.0	14.7	1.0	12.7	1.0	14.9	1.0
1-2	40.4	41.0	1.7 (1.1-2.5)	39.0	1.8 (1.2-2.5)	37.0	1.9 (1.1-3.1)	36.3	1.5 (0.9-2.5)
3-4	19.3	28.3	2.3 (1.6-3.4)	31.3	2.8 91.6-5.0)	36.5	3.6 (1.9-7.0)	29.0	2.3 (1.2-4.2)
5+	10.8	13.7	2.0 (1.2-3.2)	15.0	2.5 (1.4-4.5)	13.8	2.4 (1.2-5.0)	19.8	3.0 (1.5-6.1)
NO DSM-IV DIAGNOSIS									
Age 18-29	41.9	34.0	1.0	32.8	1.0	26.7	1.0	29.8	1.0
30-39	21.6	19.7	1.1 (0.8-1.5)	23.5	1.4 (1.0-2.0)	22.5	1.6 (1.0-2.6)	23.4	1.5 (0.9-2.5)
40-49	16.5	19.4	1.5 (1.0-2.2)	16.7	1.2 (0.8-1.9)	20.1	1.9 (1.1-3.2)	14.6	1.2 (0.6-2.4)
50+	20.0	26.9	1.6 (1.1-2.4)	27.0	1.6 (1.3-2.1)	30.7	2.3 (1.4-3.6)	32.2	2.1 (1.4-3.2)
Sex: Female	52.8	55.7	1.1 (0.8-1.4)	62.6	1.5 (1.0-2.1)	54.7	1.0 (0.7-1.6)	56.6	1.1 (0.7-1.7)

	No health Care	Western Medicine	OR (95% CI)	Alternative Medicine	OR (95% CI)	Western & Alternative	OR (95% CI)	Traditional Healer	OR (95% CI)
Race: Black	76.0	76.1	1.0	89.7	1.0	87.2	1.0	95.8	1.0
Coloured	10.7	6.6	0.6 (0.3-1.3)	3.6	0.3 (0.1-0.7)	3.7	0.3 (0.1-0.9)	1.2	0.1 (0.02-0.4)
White	10.1	12.3	1.3 (0.6-3.0)	2.9	0.2 (0.07-0.8)	3.6	0.3 (0.1-1.2)	0	-
Indian/Asian	3.2	5.0	1.6 (0.9-2.9)	3.8	0.9 (0.5-1.8)	5.5	1.4 (0.8-2.5)	3.0	0.7 (0.3-1.6)
Currently married	48.9	57.1	1.4 (1.0-1.9)	54.4	1.2 (0.9-1.6)	59.0	1.4 (0.9-2.3)	58.8	1.4 (0.9-2.3)
Location: Rural	39.8	35.3	0.8 (0.6-1.1)	44.4	1.2 (0.9-1.7)	38.6	1.0 (0.6-1.5)	46.6	1.4 (0.9-2.0)
Employed	29.2	32.6	1.2 (0.9-1.5)	30.6	1.0 (0.8-1.4)	35.1	1.3 (0.9-1.8)	31.5	1.1 (0.8-1.5)
Graduated High School	40.6	39.9	1.0 (0.7-1.4)	32.8	0.7 (0.5-1.0)	34.5	0.8 (0.5-1.3)	26.6	0.5 (0.3-0.9)
Traumatic Life Events: None	42.8	30.0	1.0	25.8	1.0	24.8	1.0	26.6	1.0
1-2	39.0	38.6	1.4 (1.0-1.8)	37.0	1.5 (1.0-2.3)	31.6	1.3 (0.7-2.4)	37.1	1.4 (0.8-2.5)
3-4	13.3	20.3	2.1 (1.5-2.8)	23.8	2.8 (1.6-4.6)	28.0	3.2 (1.7-6.1)	22.5	2.4 (1.2-4.6)
5+	4.9	11.1	2.9 (1.9-4.4)	13.4	3.9 (2.2-7.0)	15.6	4.4 (2.2-8.9)	13.9	3.6 (1.7-7.7)

3.3.4 Health seeking behaviour among participants without a DSM-IV diagnosis

Similar findings were apparent in those without a lifetime DSM-IV diagnosis. However, of the subjects who sought treatment from alternative medicine, 5% sought treatment from a traditional healer, 5% of the sample sought treatment from a spiritual or religious advisor, and 2% by another type of healer (e.g. chiropractor or spiritualist) (see Table 3.3).

Black respondents were 7.4 times more likely (OR 7.4, 95% CI 3.4-16.0) to seek help from a traditional healer as compared any coloured, white or Asian /Indian participants (Table 3.5). The proportion of patients without a DSM-IV disorder who consulted a traditional healer for their emotional and mental health concerns are more likely to be above 50 years of age (OR= 2.1, 95% CI 1.4-3.2) and had experienced more than three traumatic events in their lifetime. Participants were less likely to see traditional healers if they had more than a grade 12 education (OR=0.5, 95% CI 0.3-0.9), or were coloured or white when compared to the black participants (OR=0.1, 95% CI 0.02-0.4).

The independent effects of participant demographic characteristics on mental health seeking behaviour are presented in table 3.6. Further investigations of the variables shown in Table 3.5 were examined using a number of multivariate logistic models, to control for demographics and socioeconomic variables (including gender, age, religion race, location, employment and education (See table 3.6). Being above 50 years old increased the likelihood of consulting a traditional healer (OR=2.2, 95% CI 1.4-3. 5), compared to younger respondents (18-29 years old). Being black was associated with an 87% increase of consulting a traditional healer for emotional and mental health concerns (OR=0.1, 95% CI 0.1-0.3) compared to the coloured, white, or Asian/Indian participants. Gender, location, religion, employment and education were not associated with traditional healer consultation.

Table 3.6 Results of multivariate logistic regression analysis of factors associated with consultation with traditional healer, overall and by the presence of DSM-IV defined mental disorders, in a nationally representative sample of South African adults

	Model 1 Total sample			Model 2 DSM-IV Diagnosis			Model 3 No DSM-IV Diagnosis		
Variables	OR	p	CI	OR	p	CI	OR	p	CI
Age 30-39	1.29	0.29	0.78-2.11	1.12	0.76	0.53-2.37	1.41	0.19	0.86-2.40
Age 40-49	1.46	0.09	0.95-2.26	1.82	*0.03	1.05-3.16	1.17	0.64	0.58-2.27
Age 50	1.83	*0.00	1.25-2.69	1.46	0.19	0.83-2.57	2.16	*0.00	1.35-3.38
Sex	1.12	0.49	0.80-1.58	1.15	0.60	0.67-2.00	1.11	0.64	0.71-1.75
Race	0.11	*0.00	0.05-0.22	0.07	*0.00	0.02-0.26	0.13	*0.00	0.06-0.30
Religion (< once a month)	0.95	0.85	0.58-1.56	1.12	0.75	0.56-2.23	0.72	0.31	
Religion (> once a month	0.83	0.25	0.60-1.14	0.73	0.29	0.41-1.31	0.86	0.60	
Location	1.17	0.33	0.85-1.64	1.31	0.27	0.81-2.45	1.01	0.93	0.66-1.52
Employment	1.36	*0.03	1.02-1.80	1.52	0.08	0.94-2.46	1.25	0.19	0.92-1.79
Education	0.66	*0.04	0.45-0.98	0.57	0.09	0.31-1.08	0.79	0.44	0.41-1.39
DSM-IV: Any Anxiety	1.71	*0.00	1.19-2.44						
DSM-IV: Any Mood	1.02	0.92	0.67-1.56	0.77	0.27	0.47-1.24			
DSM-IV: Any Substance	1.69	*0.01	1.13-2.53	1.17	0.59	0.66-2.06			

* statistically significant difference at $p < 0.05$

3.4 Discussion

The main results of this study are that 1) A minority of participants with a lifetime DSM-IV disorder obtained treatment in the past 12-months from Western (29%) or alternative (20%) practitioners; 2) Traditional healers were consulted by 9% and religious or spiritual advisors by 11% of the respondents; and 3) Alternative practitioner and traditional healer use in the full sample were predicted by older age, black race, unemployment, lower education and having an anxiety or a substance use disorder.

The initial finding that South Africans consult Western health practioners more frequently than alternative practitioners, including traditional healers, for their mental health care needs is consistent with a number of previous studies assessing the pathways to care in sub-Saharan Africa. For example, a study on pathways to psychiatric care in Zimbabwe indicated that individuals with an acute illness would be more inclined to first consult a biomedical health professional, and then only seek traditional care if this treatment failed (Patel et al., 1997). However, the frequency with which individuals consult a traditional healer prior to presenting to mental health services has been found to vary significantly. A study in Nigeria reported that 26% of patients suffering from a mental illness visited a traditional healer prior to presenting

themselves to a mental health services (Abiodun, 1995). Another study conducted in Ghana reported that only 6% of patients consulted a traditional healer prior to presenting themselves to mental health care services (Appiah- Poku et al., 2004)

Particularly striking is the comparatively low proportion that used traditional healers versus the higher proportion that used religious and spiritual advisors in the black population. Forty nine percent of the black respondents reported consulting with a religious or spiritual advisor and only 21% consulted with traditional healers. In the total sample 11% of the respondents consulted with a religious or spiritual advisor and 9% consulted with a traditional healer. Thus religious and spiritual advisors may be consulted more frequently than traditional healers for mental health care concerns. These results are similar to those found in a study conducted in Ghana (Appiah-Poku, 2004) that reported 14% of patients had consulted with a pastor, compared to 6% consulting traditional healers before presentation to mental health services.

Little research has been conducted on attitudes of church pastors in urban or rural Africa, although the growth of their involvement has been noted (Pfeiffer, 2006). Although anecdotal, it is believed that the advent of the faith healer can be seen as an outgrowth of the influence of urbanization, acculturation, Christianity, and the African independent church movement. It has also been argued that many of the traditional roles of the *isangoma* have been assumed by the faith or spiritual healer (Edwards et al., 2003). Evidence for this change, is provided by a study conducted in Zimbabwe in 2002-2003 as part of a larger study of African Independent Church (AIC) and Pentecostal expansion. Members and recent converts of ten churches were interviewed in addition to in depth interviews with 80 pastors, prophet healers, traditional healers and other community leaders. In these interviews the common theme of payment and how it influenced the authenticity of the traditional healer's practices emerged frequently (Pfeiffer, 2006). Therefore, spiritual advisors place themselves at the cusp between what they refer to as the backward and outdated traditional healers and the modern, scientifically based Western medicine (Freeman & Motsei, 1992).

Service use by participants in the total sample was predicted by older age, black race, lower education, employment, and having an anxiety or a substance use disorder. The findings that older participants were more likely to seek care from traditional healers, is consistent with previous research suggesting that younger participants in Ethiopia were more likely to seek health care from modern health services (Berhane, Gossaye, Emmelin, & Hogberg, 2001). The finding that blacks are more likely to consult with traditional healers than whites, Asians

or Indians is in keeping with the beliefs that many black South Africans may hold about traditional healers (Edwards et al., 1983). For example, in a retrospective study at a hospital in Durban, the first hundred files of psychiatric patients treated during 1980, who explained the etiology of their problems in traditional terms were analyzed. The sample constituted 29% of the total Black psychiatric population treated at the hospital over the time period. Of these patients, 81% had their traditional beliefs confirmed by a traditional healer (Edwards et al., 1983). Additionally, individuals with little or no formal education were more likely to consult traditional healers than those South Africans who were more educated. This may be because respondents with more education are educated in the Western biomedical model and are therefore more likely to pursue Western biomedical help.

The cost of treatment was relatively expensive in this study and was similar between both Western (R318) and traditional healing systems (R321). Similarly, a study conducted in KwaZulu-Natal examined patterns of health seeking behaviour prior to the death of 1282 individuals. Information on the health care choices and expenditures of these individuals who died between January 2003 and July 2004 were provided by the primary care giver. Fees for consulting a traditional healer ranged from 0- R4000, with an average of R433 (Case et al., 2005). Given the expense, it is not surprising that being employed was associated with traditional healer use. Furthermore, traditional healer service use was predicted by the presence of a mental illness, with those suffering from an anxiety or substance abuse disorder being more likely to seek traditional healer services. These findings are consistent with previous data from clinical samples indicating that the majority of patients and their families consulted with a wide variety of health professionals in an attempt to obtain effective treatment, irrespective of cost (Appiah- Poku et al., 2004; Ensink & Robertson, 1999).

This data suggests that living in a rural area was not a predictor of traditional healer use. While it has been argued that the belief in witchcraft is more common in the rural areas, traditional healing practices continue in urban settings. In many settings the notion of witchcraft may be fuelled by income inequality, competition and insecurity (Nattrass, 2005). If this is the case one would expect to find a similar portion of both rural and urban South Africans who hold beliefs in witchcraft (Ashforth, 2005) and consequently consult with traditional healers.

Furthermore, 5% of the respondents indicated that they received treatment from a traditional healer despite not having a lifetime DSM-IV diagnosis. This is consistent with a study

conducted in the United States as part of the World Mental Health Survey. Results indicated that a majority (73.5%) of the respondents without a DSM-IV diagnosis sought treatment from the human services sector (30.7%) or the complementary and alternative medicine (CAM) sector (42.8%). The human service sector included religious or spiritual advisors, social workers and counsellors not specialized in mental health, while the CAM sector included any other type of healer (e.g. Chiropractor), internet support groups and self-help groups. Only 8% of respondents with a low-need for treatment received treatment from the mental health or general medical sectors (Druss et al., 2007). Additionally, a study conducted in Nigeria as part of the World Mental Health Survey found low rates of use of complimentary medicine in those with a DSM-IV diagnosis (4%), but much higher rates were found in those seeking treatment without a DSM-IV diagnosis (57%) (Gureje & Lasebikan, 2006).

The results of the present study have implications for addressing the issue of limited psychiatric care in South Africa. Given the relatively low number of Western psychiatric practitioners, there may be value in working with traditional healers and spiritual advisors in this regard. Acknowledging the possible role of churches in providing care together with educating and working with church pastors may be an important way forward in improving mental health care if their practices have been shown to effective and safe (Appiah-Poku et al., 2004). Traditional healers and religious and spiritual advisors are widely dispersed throughout South Africa, are knowledgeable of the culture norms, and their advice is sought, believed and acted upon by community members. Organized and well trained traditional healers and religious and spiritual advisors have the potential to play a significant role in mental health treatment and as a referral resource in the South African context (Peltzer et al., 2006).

Several limitations of this study must be considered when interpreting these findings. Firstly, the study relied on respondents' recall of treatment of the past 12 months. Although the evidence is anecdotal, stigma about consulting traditional healers may have led to an underestimation of traditional healer use. Secondly, the study did not include South Africans who live in institutional settings including mental hospitals and therefore these findings may not hold for severely mentally ill patients. Thirdly, we did not have data on which service provider the subject saw first. More information on this would be helpful in understanding pathways to treatment. Fourthly, respondents may be reluctant to admit to consulting a traditional healer to a research assistant who is perceived as representing Western medicine.

Finally, the categories of treatment providers created for the purpose of this study resulted in a perhaps over simplified approach that does not necessarily conform to the realities of these complex relationships.

Despite these limitations, this data is the first to describe the use of alternative medicine for mental health care in a nationally representative population sample in South Africa. The study revealed that alternative medicine is widely used amongst South Africans, and therefore there is potential to educate both traditional healers and religious and spiritual advisors on common mental disorders. Furthermore, it is important to educate the South African population about the positive and negative consequences of alternative practices to ensure they are making fully informed decisions when choosing the appropriate health practitioners. Poor knowledge (low mental health literacy), negative attitudes, and fear of stigma are likely to influence the help-seeking behaviour of South Africans, and education has the potential to have a positive impact on the mental health situation in South Africa (Peltzer et al., 2006). Future research should focus more exclusively on the roles that religious and spiritual advisors and traditional healers play in the South African context, in addition to an assessment of the effectiveness of their mental health practices.

This chapter has examined the extent to which traditional healers are being used in South Africa for mental health concerns. In the next chapter, I investigate how traditional healers both understand and treat mental illness.

CHAPTER 4

EXPLANATORY MODELS OF MENTAL DISORDERS AND TREATMENT PRACTICES AMONG TRADITIONAL HEALERS

4.1 Background

The second and third research question proposed in Chapter One was to investigate the explanatory models and treatment practices of non-psychotic mental disorders among South African traditional healers. In Chapter Two, the literature available on explanatory models of mental illness was described in detail (pg.20), in addition to the limited research available investigating the treatment practices of traditional healers for mentally ill patients, especially for non-psychotic disorders (pg. 43). A brief summary follows.

According to the few studies conducted in Africa investigating the explanatory models of mental illness, there appears to be a distinction between those of psychotic (e.g schizophrenia and bipolar disorder) and non-psychotic disorders. Aidooi & Harpham, 2001; Patel et al., 1995a, 1995b). Patel (1996) hypothesizes that many Africans are unable to distinguish between non-psychotic and psychotic disorders, since many do not identify non-psychotic disorders as being related to mental illness. Whether there is enough data to support this view is debatable since only a few studies have been conducted addressing this issue, none of them recent, and few outside Zimbabwe. Therefore, drawing conclusions about "Africans" based on a few studies seems unwarranted

Although a few studies have been conducted in South Africa investigating traditional healers' perceptions of, and approaches to the treatment of mental illness, none of them have specifically examined non-psychotic disorders (Koen et al., 2003; Mufamadi, 2001; Mzimkulua & Simbayib, 2006; Robertson, 2006; Thorpe, 1992). In order to elicit the illness beliefs of the general public and various community workers, including traditional healers, case vignetess of non-psychotic disorders are often used (Alem et al., 1999; Patel et al.,1995b; Okello, 2006).

There are a number of reasons that it is important to investigate traditional healers' explanatory models and treatment practices for mental illness. An understanding and appreciation of the concepts of mental illnesses held by traditional healers, and their treatment

practices, would help plan for mental health services in the developing world and might shed light on the debate concerning the most appropriate way to collaborate with traditional healers. It is also important for South Africans to be informed about the practices of healers in relation to mental health care so they can make an informed decision about their choice in mental health providers.

The purpose of the present study is to identify concepts, causes, and treatments for mental disorders. More specifically we will: (a) explore traditional healers' basic concepts of mental illness including treatment; (b) contrast views of a vignette with psychotic (schizophrenia) and vignettes with non- psychotic mental disorders, including depression, panic disorder and somatization

4.2 Methods

4.2.1 Setting and sample

The South African Depression and Anxiety Group (SADAG) is a mental health advocacy group in South Africa. The group provides workshops for a variety of community members, including home-based care workers (HBCWs), educators, police, students, youth leaders and traditional healers. For this study, a convenience sample of 50 traditional healers was selected from those who attended the workshop conducted by SADAG in the province of Mpumalanga. The traditional healers were from Lydenberg, Sabie, Standerton, Bethal, Bushbuckridge and Komatipoort. According to the 2001 census, Mpumalanga has a population of 3 122 990. The population distribution by racial groups in Mpumalanga consist of around 92.4% African/Black people, 0.7% Coloured people, 0.4 % Indian/Asian people and 6.0% White people. While 30.8% of the population reported Siswati as their home language, 26.4% speak iZulu.

4.2.2 Procedure

The study adopted a cross-sectional exploratory design, using qualitative methods that included 4 focus group discussions (8 healers in each group) and 18 in-depth interviews. The total number of participants in the study was 50. All interviews and focus groups were conducted prior to the workshops. On arrival at the community hall, traditional healers were asked to participate in the study. All of the healers approached agreed to participate.

In order to obtain information on mental disorders, four vignettes were presented (schizophrenia, depression, panic and somatization) from the Short Explanatory Model Interview, (SEMI) (Lloyd et al. 1998). A short interview was used to elicit explanatory models of traditional healers' views on the nature of the problem, cause, consequence, treatment and patient expectations (See Appendix 1). During the discussion the moderator read each vignette slowly for everyone to hear clearly and understand, and clarified anything that was uncertain before initiating the discussion. This was done in order to ensure the uniformity and clarity of the symptoms presented in the vignette, and also to allow the participants who could not read the material to participate in the study. The interviews and focus groups were conducted predominately in Zulu and Siswati, using translators. All participants provided written informed consent prior to inclusion in the study.

4.2.3 Data Management & Analysis

The qualitative data analysis for this study was conducted using the framework approach (familiarization, identifying a thematic framework, indexing, charting, mapping and interpretation). Initially, focus group responses were read for emergent themes, which were then coded. Care was taken to ensure the codes accurately captured the respondent's meaning. A second researcher independently coded the interviews to ensure validity of the categories. We used NVivo 7.0 (QSR international, 2007), a qualitative software program for data analysis.

4.3 Results

Results are presented in accordance with sub-aims of this study. Results are divided into: (1) characteristics of traditional healers; (2) basic concepts of mental illness including treatment; (3) views on how schizophrenia is conceptualized and treated; (4) views on how depression is conceptualized and treated; (5) views on how panic disorder is conceptualized and treated; and (6) views on how somatization disorder is conceptualized and treated.

4.3.1 Characteristics of traditional healers

Table 4.1 summarizes the characteristics of the traditional healers who participated in this study. The majority of the healers interviewed were women (64%), with an average age of 45 (SD=0.59) years. A majority of the healers in this study can be classified as diviners (86%)

(those who have diagnostic powers) or herbalists (10%) (those who dispense herbal medicines). Four percent of the participants described themselves as being both a diviner and herbalist. Among the healers interviewed, the average education level was Grade 6 standard 4 (SD = 2.8), equivalent to six years of schooling, and 58% were illiterate. Their mean duration of practising as a traditional healer was 25 years (range: 6 months - 30 years), with an average length of training of 3 years.

Table 4.1: Socio-demographic and practice characteristics of traditional healers (N=50)

Characteristic	(%)
Gender	
Female	64
Literate (%)	42
Type of Healer (%)	
Herbalist	10
Diviner	86
Faith Healer/Diviner	4
Age in years (mean, sd)	45 (0.59)
Years of education (mean, sd)	4 (2.8)
Duration of training in years(mean, sd)	3 (2.8)
Duration of practice in years (mean, sd)	25 (0.21)

4.3.2. Basic Concepts of Mental Illness

All healers recognized "mental illness" as a distinct category of illness, and a majority reported having seen people with mental illness either at the time of the interview or in the previous 3 months (86%). Although some healers reported consulting with ancestors to aid in the diagnosis of a mentally ill patient (34%), all healers reported being able to diagnose a patient by their extreme behavioural disturbances. The more frequently reported behaviours included: violence, picking up garbage, talking randomly, walking for long periods of time and undressing in public. Descriptions of patients with mental illness include:

> *"There is a lady that never even bathed herself, she didn't want to. She didn't even use the toilet and then she always wanted to go gallivanting because she hears people calling her, that are luring her towards them. She says their names and told us what they are telling her to do. She was very violent, trying to fight with people all the time"*

"Mental illness is different to stress and heart illness 'cause mental ill person will live alone, damage property and say many useless things. They do not stay at one place are very restless and talking to themselves not making any sense. They pick up dirt from dust bins, they do not wash and they beat other people up for no reason"

The healers held that mental illness could have many causes, of which witchcraft and possession by evil spirits were the most frequent (56%). Witches were believed to have the ability to mobilize their evil powers and the forces of nature to harm other people. The term *amafufunyana* (12%) was also used to describe mental illness caused by witchcraft, mostly by the Zulu-speaking respondents. Amafufunyana is a serious disorder often reported to be caused by witchcraft. Some believed that the illness was a consequence of causal factors (family problems, substance abuse, and poverty) that were left untreated and progressively became more severe (30%). Additionally, substance abuse was mentioned as a possible cause by a few of the healers (12%). A further belief reported by the healers was that when ancestors call an individual to become a traditional healer, they inflict a mental disorder on that person before the period of spirit possession begins (*ukuthwasa)* (10%). An example given with regard to this cause of mental illness includes:

"The ancestors are trying to tell that person that they should follow the calling and become a traditional healer. The ancestors can cause a number of problems to a person if they do not listen to the calling, even a mental illness. A calling can be viewed as a blessing and a burden"

The belief in varying causes of mental illness is conveyed by the following statement:

"It is true that a person gets mentally disturbed if they don't do their family rituals, or traditions. Another person gets mad because they were abused, another because they killed someone and then you find that some people have a calling, to become traditional healer. We can help patients who have a mental illness caused by African reasons"

According to the traditional healers, the effects of a mental illness extend beyond the illness itself. A few of the healers mentioned that mentally ill people may lose their jobs, making them incapable of caring for their family (24%). Also, many of the healers acknowledged that mentally ill patients are often ridiculed by community members (86%) and become very lonely and isolated in their community (24%).

However, a mentally ill person requires a great deal of caring and support, and it is usually the family who takes on this responsibility (86%), as is portrayed by this example:

> *"Healing can be expensive, and families end up paying for the patient. They just want them to be better, no matter what. I had patient once whose family was desperate for cure. He would throw things at neighbours house and start fights. Other community members laugh at the sick patient too, this is very bad"*

In this example, the family was held responsible for the young man's outrageous behaviour. As a result of this blame associated with mental illness, develop within families and communities. This only exacerbates the financial burden placed on the family. Although the traditional healers were describing stigma, they did not use a particular word that was equivalent in meaning.

A majority of the healers reported that they possessed the skills and knowledge required to "cure a mental illness" (86%), and often treated the patient by encouraging them to live with them in their home (90%). The duration of living with the healer ranged from two weeks to a year and a half. This ensured the patient adhered to the treatment and that someone was always there to take care of the patient. Some described situations where patients became very violent and would not take their treatment. Forceful methods such as tying them up with ropes and chains were described (34%), in addition to getting the police involved in order to transport the patient to the clinic (12%). The healers reported a structured treatment regime, with the patient given specific instructions to take their treatment. This is encapsulated by the following statement:

> *"I have a mentally ill patient, who had gone to the Western doctor and did not get cured. His family took him to me and he stayed with me for 5 months. He took 1 teaspoon of muti 3 times a day with food. Although he does not live with me anymore, he still takes his muti. He is much better now and will soon be cured".*

All of the healers reported that mentally ill patients would be given "muti" to drink and bathe with, while more than half also described treatment involving sniffing herbs through the nose (52%). A majority of the healers could not (or would not) give precise names of the herbs that they were using to treat patients suffering from mental illness (86%). Many of the healers

claimed that they did not want to divulge such information as they considered their knowledge of plants and medicines to be inherently secretive, and were only to be shared with their initiates. However, a few were prepared to divulge this knowledge. For example, in a focus group discussion, 8 diviners asserted that the use of Dettol® (a commercial liquid antiseptic) mixed with water and herbs was effective in treating mentally ill patients. Furthermore, one diviner provided specific details of the ingredients to cure *amafufunyana*. The healer claimed to be given this recipe by a talented herbalist, and has shared this knowledge with her initiates and other traditional healers.

1. 1 teaspoon Methylated spirit
2. ½ teaspoon Benzine (colorless, highly flammable liquid- used as a cleaning agent)
3. a few pieces of Indonya (a traditional herb- looks like Epsom salt)
4. 1 teaspoon of vinegar (any type)
5. ½ teaspoon of umdlebe (you grate this particular herb)

All of these ingredients are mixed together and administered to the patient suffering from *amafufunyana*. The healer claimed that in only a few minutes the *amafufunyana* spirit begins to release. Appropriate rituals are then conducted to complete the healing process. The healer also discussed how Western practitioners would probably not approve of this treatment due to the use of Benzine. However, the healer claimed that this treatment was effective, and having the ability to cure *amafufunyana* allows her to become a specialist in treating this particular illness, resulting in a greater number of patients.

4.3.3 Views on Specific Mental Illnesses

Schizophrenia- Case Vignette

Tshepo is 44 years old. She has not worked for years. She wears the same clothes all the time and has left her hair to grow long and untidy. She is always on her own and is often seen sitting alone and talking to herself. She is hearing voices, and believes that the government and the police are out to get her. She thinks that people are spying on her and that they know what she is thinking. Although she is polite, she does not like talking to other people. She has asked her landlord to put extra locks on her door and to remove the television set from her room. She says spies are trying to keep an eye on her because she has secret information.

A majority of the healers reported that the patient described in the "schizophrenia" vignette was not suffering from a mental illness (60%). Some of the healers reported that the patient was being called by his ancestor to become a traditional healer (30%). This belief is conveyed by the following statement:

> *"It is her ancestors that are talking to her and want her to become a traditional healer by accepting the calling. She must come see a senior traditional healer. We can help her. If she does not accept the calling things can go very bad"*

The remainder reported that the patient was "thinking too much" (13%) or was suffering from stress caused by frustration and social problems (17%). However, on further enquiry, if told that the patient in the vignettes was also very violent and aggressive, a minority changed their mind and reported that the patient was probably suffering from a mental illness (30%).

About 40% of the healers in the study believed that the patient portrayed in the "schizophrenia" vignette was suffering from a mental illness. Of these healers, a majority reported that the cause of the patient's suffering was witchcraft, (25%); some specifically used the term *amafufunyana* (10%). Other healers believed the suffering of the patient in the schizophrenic vignettes was caused by their ancestors (*thwasa*) (10%), or substance abuse (5%).

Agoraphobia and Panic Disorder- Case Vignette

> *Brian, a 34 year old taxi driver, goes to see a traditional healer. He can not get on a bus since a friend of his was attacked at work. He has been off work for four months now. Because of this his family has money problems and they are very late paying their rent. He used to go shopping with this wife, but now does not like going into supermarkets. When he is around a lot of people he starts sweating and feels stressed and panicky. When this happens he feels that something bad is going to happen to him. He now spends much more time inside*

Almost all of the traditional healers did not believe that a man suffering with agoraphobia and panic attacks was suffering from a mental illness (98%). However 60% did believe the individual in the vignette was suffering from an illness. The reported illnesses ranged from

HIV/AIDS (16%), illness of the heart (8%), hypertension (12%), ancestor calling (6%), and stress (16%). These illnesses were reported to require the attention of a traditional healer (42%) or a Western doctor (16%). All of the healers reported that they had the ability to cure these illnesses, however if they found their patients were not responding to their treatment they would refer their patient to a Western doctor.

Of the traditional healers who reported these symptoms as not being an illness (40%), the problems reported were stress (16%) or thinking too much (24%). When it came to treatment, all of these traditional healers reported that there was no medical treatment available that would help someone with this disorder. However, counselling and providing practical support (money or employment) were often reported as useful alternatives.

Depression- Case Vignette

> *Jennifer is a 29 year old single mother with two small children. They live in a small, old house that is paid for by benefits. She feels low in energy, has lost weight, does not sleep well and feels the worst in the mornings. She feels her life is not worth living and worries about what will happen to her in the future. At times, if it was not for her children she think she may end her own life. Her boyfriend pops in from time to time but is not prepared to contribute to childcare.*

None of the traditional healers in this study believed that the patient described in the vignette was suffering from a mental illness. A majority of the healers reported that these problems were caused by psychological reasons (for example, stress or thinking too much) (62%), while others believed they may have been caused by bewitchment (12%). Many of the healers (68%) did believe that the patient was suffering from an illness that required the attention of a traditional healer (40%) or a Western doctor (28%). Among the healers that believed the patient was suffering from an illness, the reported illnesses ranged from stress (38%), bad spirit (8%), HIV/AIDS (8%), illness of the heart (8%) and thinking too much (6%). All of these healers felt they had the capabilities of curing these patients of these problems.

Of the traditional healers who reported that the patient in the vignette was not suffering from an illness (32%), the problems reported were stress (18%) and thinking too much (14%). Since the healers did not consider the patient to be ill, there was no treatment option available for them. However, some of the healers (28%) reported that if the patient does not effectively

deal with their life situation these symptoms had the potential to deteriorate and develop into a mental illness

Somatization Disorder Case Vignette

> *Sarah, a 45 year old machine operator, married with two children has been feeling tired, a little angry and does not have much energy. She has trouble getting to sleep and she gets stomach pains and her back and legs ache most of the time. Because of this she has problems caring for her children and does not enjoy being around them like she use to. She has been to many traditional healers (and doctors). But no one can find anything wrong with her. She now wants to sit around the house watching the television.*

None of the traditional healers in this study believed that the patient described in the vignette was suffering from a mental illness. A majority of the healers (74%) believed the patient's symptoms were due to psychological problems, such as excessive worry or thinking too much, while the remainder believed the symptoms were due to a physical problem (26%). Of the healers that believed the patient was suffering from an illness (70%), the reported illnesses ranged from stress (30%), physical problem (6%), hypertension (10%) HIV/AIDS (8%), and thinking too much (6%). These healers believed they had the capabilities of curing these patients.

Of the traditional healers who reported these symptoms as not being an illness (30%), the problems reported were work related (10%), children related (6%) and thinking too much (12%). These healers did not consider any treatment options for this patient, since the individual is not suffering from an illness.

4.4 Discussion

The main results of this study are as follows. First, psychotic illnesses appear to be the main exemplar of mental illness, often being associated with severe behavioural disturbances. Second, traditional healers hold multiple explanatory models for psychotic and non-psychotic disorders. For non-psychotic disorders, those that did not report the problem to be of a physical nature, often conceptualised these disorders as more stress-related, or a result of "thinking too much", and believed that people suffering from non-psychotic disorders did not always require treatment. Third, traditional healers do not only use herbs and substances solely from "traditional" sources but rather have incorporated modern ingredients that are potentially toxic into their treatment practices.

Consistent with previous findings, healers in the present study reported severe behavioural disturbances as being associated with mentally ill patients, which can be caused by a multitude of factors (Mufamadi, 2001; Mzimkulua & Simbayib, 2006; Patel, 1995, 1997). Results of the present study revealed that the symptoms presented by a mentally ill patient are predominantly behavioural and include undressing and urinating in public, violent and aggressive behaviour. Additionally, multiple causes of mental illness were described, including witchcraft, possession by evil spirits, substance abuse, life stressors and *thwasa* (calling to be a healer). However, according to Mzimkulu and Simbayi (2006), the healers in their study reported that psychosis was differentiated from *thwasa* in that individuals suffering from thwasa do not present with inappropriate or bizarre behaviour, and do not have difficult maintaining their personal hygiene. Results of the present study did not uncover this distinction.

Additionally, many of the healers in the present study did not believe that a patient with schizophrenia was suffering from a mental illness, but rather their symptoms were simply a result of the patient being called by his ancestors to become a traditional healer *(thwasa),* "thinking too much" or suffering from stress caused by frustration and social problems. According to the healers, behaviours such as hearing voices, talking to oneself, and social withdrawal, are not always regarded as signs of a mental illness. Since a quarter of the healers altered their answer when told the patient in the vignette was violent and aggressive, it may be that traditional healers are more likely to diagnose a patient as mentally ill if they show signs of extreme antisocial behaviour or a behaviour that is not just problematic to the individual, but to the community as well.

Although, the findings of the present study support Patel's (1996) conclusion that psychotic illnesses appear to be the main exemplar of mental illness, according to the present study the distinction between psychotic and non-psychotic disorders is not that straightforward. Unlike the present study, Patel's research in Zimbabwe did not elicit the explanatory models of psychotic disorders using vignettes. The healers' concept of mental illness was elicited by asking the participants to simply describe mentally ill patients.

However, as traditional healers can be regarded as cultural experts, their beliefs and experiences do not necessarily coincide with the beliefs of lay people. The literature suggests that it is common for traditional healers to hear the voices of their ancestors (Hammonde-

Tooke, 1989; Ngubane, 1977). It may be that traditional healers were reluctant to report that the patient in the vignette was suffering from a mental illness, as they themselves may be ukuthwasa survivors and hearing the voices of ancestors informing them on how to conduct their daily lives and treat patients is an everyday occurrence (Edwards, 1984). This could explain why many of the healers used the term *thwasa* to describe the patient in the schizophrenic vignette, which most reported was not suffering from a mental illness. Especially since they did not think the problems described in the vignettes was strange or negative. This coincides with the view of some authors that describe *thwasa* as a positive health experience involving the calling by the ancestors to become a traditional healer (Buhrmann, 1977; Schweitzer, 1977). However, a few of the traditional healers in this study did consider the patient with schizophrenia to be suffering from a mental illness and also used the term *thwasa* to describe the patient. This coincides with the suggestion that only a minority of those diagnosed with *thwasa* will eventually become qualified healers. If the initiate does not graduate, which also implies recovering from *thwasa,* they will be re-diagnosed as suffering from *ukuphambana* (madness) (Schweitzer, 1977).

Although a majority of the healers did not consider the people in the non-psychotic vignettes to be suffering from a mental illness, many considered them to be suffering from other illnesses such as HIV/AIDS and hypertension. The emphasis on HIV may be an indication of HIV awareness among the population. Furthermore, since HIV is often linked to depression and other non-psychotic disorders, traditional healers may view all people experiencing these symptoms as having HIV as opposed to the non-psychotic disorders in isolation from HIV infection. Also, similar to a study conducted by Blumhagen (1980), the term hypertension may have been used to describe heightened psychological states of tension as opposed to a medical diagnosis of elevated blood pressure.

The traditional healers in the study hold multiple explanatory models of non-psychotic disorders. A majority of the healers regard non-psychotic disorders as a reaction to difficult life situations and as a relatively normal reaction to severe social and personal threats and losses. Therefore, a non-psychotic disorder would not be identified as a mental illness unless it acquires other characteristics such as severe behavioural disturbance. This definition of mental illness is notably different from that provided by Western medicine. These findings are relatively similar to previous studies conducted in Africa (Aidooi & Harpham, 2001; Okello, 2006; Patel et al, 1995a, 1995b) and coincide with Patel's conclusion that many Africans do not consider non-psychotic disorders to be mental disorders (Patel, 1995, 1996)

Since many of the healers did not consider a non-psychotic disorder to be a mental illness, many reported that there was no treatment available for these kinds of problems. However, a number of healers described more practical ways they could help these patients, such as giving them money or helping them find a job. In addition, many of the healers mentioned counselling, which could be provided by either a Western or traditional health care professional, as an option to help these patients. The healers that reported that the patients in the non-psychotic vignettes were suffering from physical disorders (such as HIV/AIDS, hypertension and other physical problems) claimed they had the skills to treat these illnesses.

In terms of investigating how traditional healers treat mentally ill patients specifically, some key preliminary findings emerged. It appears traditional healers do not solely utilize traditional herbs as ingredients for their treatment; rather they have incorporated "modern" ingredients into their practices. However, the safety of ingesting "modern" ingredients (such as methylated spirits) warrants concern. The healers may have been more willing to describe treatments that the researcher would recognize, or in other cases were afraid that the researcher would exploit their indigenous knowledge. The possibility also exists that the traditional healers themselves do not have specific knowledge of the herbs they use, such as the extent of their medicinal properties.

The results of this study have implications with regard to traditional healer practices and Western mental health services. To begin with, it would appear that traditional healers have a relatively low level of mental health literacy, and some may be misdiagnosing patients with mental illness with HIV or hypertension. Many mental illnesses, such as depression, can potentially be life threatening, and are often associated with suicide. The lifetime risk of suicide in those affected by major depression and bipolar has been estimated at 6–15% (Inskip, Harris, & Barraclough, 1998). Interventions designed to increase the mental health literacy of traditional healer and to encourage referral practices for the mentally ill would be beneficial.

Secondly, collaboration between traditional healers and mental health practitioners is important with regard to effective diagnosis and treatment of mental illness. At the present time, collaborative efforts involving "Western" and traditional practitioners take on the form of a one-sided unidirectional, educative approach. There is evidence to suggest that traditional

healers have shown greater influence in treating illnesses where behaviour change is required, such as HIV prevention and adherence to TB medication (Colvin et al., 2003). Although formally engaging traditional healers in treating mentally ill patients may prevent appropriate diagnosis and treatment for the mentally ill, a pragmatic approach would be to work within the current structures for positive change. Traditional healers in the study reported taking mentally ill patients into their own households. If these patients sought treatment from a Western medical professional, traditional healers could potentially play a pivotal role in ensuring their adherence to treatment and providing a setting where they can integrate back into the community.

Finally, the importance of investigating the effectiveness of traditional healer treatment – specifically in regard to mental illness - is gaining greater significance. All people have the right to medicines and treatment that are safe and effective. Medicines, whether 'Western' or traditional, should fulfil the same uniform standards, tests and trials before being made available to the public. Achieving this goal is one of the main objectives of the Indigenous Knowledge Systems [Health] Lead Programme at the MRC. The program focuses on research into traditional systems of health care by evaluating the effectiveness of traditional remedies through internationally accepted scientific methods (South African Medical Council, 2008).

Several limitations of this study must be considered when interpreting these findings. Firstly, as this was a qualitative study that utilized a convenience sample of traditional healers from Mpumalanga, the results cannot be generalized to the South African traditional healer population. Much of the literature reported on explanatory models is from Zimbabwe or the Eastern Cape, therefore, some of the differences between findings may have been due to the different settings. Secondly, the study does not provide the actual words in the African language(s) that were used to denote key concepts. Thirdly, the study was conducted in African languages, which the person collecting the data (KS) does not speak. The interview schedule had to be translated from English to Zulu//Siswati/Xhosa and the responses translated back to English, creating increased opportunity for error. Also, the researcher being perceived as an outsider could have also effected the results of this study. This became apparent when trying to elicit substantial information on the treatment practices of traditional healers specifically in regard to mental illness. Finally the use of vignettes to elicit participants' beliefs on CMDs resulted in their conclusions being limited to the responses given to the cases presented and cannot be assumed to be identical to the participants' responses to real life situations

However, despite these limitations, this study has contributed to the understanding of traditional healers and mental illness in South Africa. The most important finding of this study is the low levels of mental health literacy among South African traditional healers. Furthermore, due to the potential harm of traditional healer treatment of mentally ill patients, Western health care practitioners should be advised to ask a patient if they had consulted a traditional healer before and what recommendations were made, and to discuss the implications of simultaneous traditional and Western healing interventions.

Future research should focus on replicating this study using larger samples that represent traditional healers from various regions across South Africa. Also, identification and examination of the pharmacological effects of the medicinal plants (and modern substances) used to treat mentally ill patients (as defined by the healers) should be assessed, in order to assess their ability to treat mental illness and any harmful side effects that may result. Finally, training programs to increase the mental health literacy of traditional healers should be developed and the effectiveness of the program assessed.

Numerous training programs and intervention strategies have been adopted to educate traditional healers in the fundamentals of a number of health care issues. A majority of the training programs focus on HIV/ Medicine. The next chapter will assess whether interventions for educating traditional healers about STD and HIV medicine are efficacious.

CHAPTER 5

INTERVENTIONS FOR EDUCATING TRADITIONAL HEALERS ABOUT STD & HIV MEDICINE

5.1 Background

The fourth research question proposed in Chapter One, was to determine whether interventions for educating traditional healers about STD and HIV medicine are efficacious. The Literature review (Chapter 2) provides more detail on the various interventions adopted. A brief summary follows.

The HIV and AIDS epidemic is a global catastrophe, with a particular burden in the developing world. In 2006, it was estimated that approximately 39.5 million people were living with HIV, 4.3 million were recently infected and 2.9 million people died from the devastating epidemic (UNAIDS, 2006). Developed countries have not remained untouched by this epidemic; however, countries such as Africa, Asia, and Latin America lead the world in HIV infection. For example, of the 39.5 million people living with HIV worldwide in 2006, more than 63% were from sub-Saharan Africa.

Individuals may consult traditional healers for the treatment of sexually transmitted infections (STIs) because they offer great cultural and conceptual familiarity by meeting the needs and expectations of the patients and by paying attention to social and spiritual matters (King, 1997). There is a strong argument for the importance of collaborating with traditional healers in the management of STIs such as HIV/AIDS (Mills, Singh, Wilson, Peters, Onia, & Kanfer, 2006). Political and health care systems have failed adequately to cope with the pandemic, and engaging every available resource is therefore crucial. One such potential resource is treatment by traditional healers.

Various intervention strategies have been adopted to educate traditional healers in the fundamentals of STI and HIV medicine (Green, 1994; Green et al., 1995; King & Homsey, 1997; UNAIDS, 2000, 2002). However, no systematic review has thus far attempted to determine whether interventions to educate traditional healers in HIV and STI medicine result in an increase in knowledge. The present study attempts to fill this gap by conducting such a review using the methodology of the Cochrane Collaboration. Although it would have been beneficial for this thesis to have examined studies looking at interventions aimed to educate traditional healers on mental health issues, this was not feasible since at the present time only 1 study has been located and it was not an RCT (Adelekan et al., 2001).

5.2 Methods

5.2.1 Criteria for considering studies for this review

Types of Studies

All intervention studies that used a controlled design, (randomised controlled trials (RCTs), controlled clinical trials (CCTs), controlled before and after studies (CBAs)) that have evaluated the effect of interventions on any one of the outcome measures specified were included in this review. Publication is not necessarily related to study quality and, indeed, publication may imply certain biases (Dickersin, Min, & Meinert, 1992; Song, Eastwood, Gilbody, Duley & Sutton, 2000); therefore, unpublished abstracts and reports were also considered. Trial reports in all languages were included.

Types of Participants

All traditional healers (including native, aboriginal and indigenous healers) practicing in the developing and developed world were included regardless of whether they were still in training or were members of an organizational body (e.g., the Traditional Healers Organization).

Types of Interventions

The review focused only on interventions aimed at educating traditional healers in STI and HIV medicine. Comparisons were conducted between educational interventions versus no intervention. Both short-term and long-term interventions were included, where available.

5.2.2 Types of outcome measures

Primary Outcomes

Change in knowledge about STI and HIV medicine. This included knowledge surrounding HIV transmission routes, prevention methods, and ART.

Secondary Outcomes

Change in behaviour including a) Reduction in HIV risk practices (e.g., performing scarifications (incisions with unsterilized blades), performing enemas with reused equipment). b) Referring patients for HIV testing c) Distributing condoms to community members d) Providing advice and counselling on safe sex practices e) Referring patients to Western medicine

5.2.3 Search methods for identification of studies

A comprehensive and exhaustive search strategy was formulated in an attempt to identify all relevant studies regardless of language or publication status (published, unpublished, in press, and in progress). This included:

1) Pubmed- searched on 4 April 2008 using the search strategy documented in Appendix 2.

2) EMBASE on line- searched on 9 April 2008. See Appendix 2 for search strategy.

3) Gateway- searched on 10 April 2008 to retrieve meeting abstracts using the search strategy documented in Appendix 2.

4) AIDSearch- searched on 10 April 2008 using the search strategy documented in Appendix 2.

5) The Cochrane Central Register of Controlled Trials (from 2004- 2008) - searched on the 10 April 2008. See Appendix 2 for search strategy.

Additionally, key personnel and organizations working in HIV/AIDS intervention programs in developing countries were contacted for published and unpublished references and data. Conference proceedings of international conferences related to AIDS (e.g., the International Conference on HIV/AIDS and STIs in Africa [ICASA]) were searched, and additional randomised controlled trials (RCTs) were sought in the reference lists of the retrieved articles.

5.2.4 Selection of studies

RCTs identified were independently assessed for inclusion by two raters (KS and JI), based on information included in the abstract and/or methods section of the trial report. Non-RCTs and other studies requiring additional information to determine their suitability for inclusion in the review were listed in the "studies awaiting assessment" table in the Review Manager (RevMan) software pending the availability of this information. Any disagreements in the trial selection procedures were resolved by discussion with a third rater (DS).

Data extraction

Spreadsheet forms were designed for the purpose of recording descriptive information, summary statistics of the outcome measures, the quality scale ratings and associated commentary. Once these data were entered, they were exported to the RevMan software, which was used to conduct the meta-analysis. Where information is missing, the reviewers will contact investigators by e-mail in an attempt to obtain this information.

Data synthesis

The following information was independently collated by two reviewers from each trial:

(a) Description of the trials, including the primary researcher, the year of publication, and the source of funding.

(b) Characteristics of the interventions, including the number of participants in the intervention and control groups, the number of total drop-outs per group as well as the elapsed time between the intervention and post-assessment.

(c) Characteristics of study methodology, including whether randomisation was employed.

(d) Characteristics of participants, including category of traditional healer (Inyanga, Sangoma, faith healer), gender distribution, mean and range of ages and descriptions of traditional healer practices.

(e) Outcome measures employed and summary of continuous (means and standard deviations) and dichotomous data.

Quality Assessment

There has been some debate about how best to measure the quality of trials, and further work in this area remains necessary. In this review, we used the quality criteria recommended by EPOC to assess study quality of all studies included in the review (EPOC Review Group Checklist, 2002).

The criteria used to assess RCTs were:

1. concealment of allocation;
2. follow up of professionals;
3. follow up of patients or episodes of care;
4. blinded assessment of primary outcomes (s);
5. baseline measurement;
6. reliable primary outcome measure(s);
7. protection against contamination.

The criteria used to assess CBA studies were:

1. baseline measurement;
2. characteristics for studies using second site as control;

3. blinded assessment of primary outcome(s);
4. protection against contamination;
5. reliable primary outcome measure (s);
6. follow-up of professionals;
7. follow-up of patients;

An overall quality rating (high, moderate, low protection against bias) was assigned to each study. A high quality rating was given if all criteria were rated as done (or not applicable); a moderate quality rating was given if one or two criteria were not done or not clear; and a low quality rating was given for studies if three or more criteria were not done or not clear.

5.2.5 Analysis

Ideally, a meta-analysis of study outcomes would have been conducted for this review. This however was not possible due to the small number of included studies and the differences in relation to methodological design and outcome measures across the studies. Consequently, the results are presented in a narrative format.

5.3 Results

5.3.1 Results of the Search

The search of the electronic databases yielded the following results: PubMed (210 records), EMBASE (35 records), Gateway (390 records), AIDSearch (4 records), and CENTRAL (70 records).

5.3.2 Included Studies

Two studies met the inclusion criteria; both of the studies assessed the effectiveness of interventions compared with control groups which received no education intervention. Two additional studies were located, but were not included since more information from the authors on the outcome measures was required. A description of all four studies is provided below:

The first study (Peltzer et al., 2006) was a controlled before and after study (CBA) investigating the effectiveness of an intervention designed to educate traditional healers on HIV/AIDS, sexually transmitted infections (STI) and tuberculosis (TB) in KwaZulu Natal, South Africa. A quasi-experimental intervention design was conducted in four selected

communities in KwaZulu-Natal, South Africa (2 urban and 2 rural). The intervention consisted of a 3.5 day training session led by one professional nurse, one traditional healer, and two researchers who facilitated the training. The intervention itself focused on information on HIV, STI, TB, nutrition and family planning, and motivation for risk behaviour reduction. A follow-up session, 2–3 months after the initial training, was conducted by the trainers to review and clarify any misunderstandings of the material provided and to overcome any challenges the healers had experienced. Traditional healers were assigned to an intervention (n=160) or control group (n=73). The questionnaires were interviewer-administered in Zulu by two researchers, one traditional healer and one professional nurse trained in administration of this interview schedule. Post-questionnaires were administered 7-9 months following the intervention. Participants assigned to the control condition completed assessments during the same periods as intervention participants.

The second study (Poudyal et al., 2003) was a controlled trial (CT) that evaluated an intervention program designed to train traditional healers in Western medicine. Traditional healers were randomly selected from a list of 269 healers from 10 village development committees in rural Nepal. 50 traditional healers were randomly selected to participate in the intervention group and 30 untrained healers were randomly selected to participate in the control group. The intervention focused on increasing traditional healers knowledge of malnutrition, acute respiratory infection, diarrhoea, night blindness and HIV, However, only the HIV/AIDS component of the training will be reported in this review. The training lasted for 7 days and was lead by four trained instructors. Data collection was conducted 1 year following the intervention using a semi-structured interview scheduled.

The third study (Nations & De Souza, 1997), for which we are awaiting further details, was a controlled-before-and-after study (CBA) using a quasi-experimental intervention design. The study evaluated an intervention designed to train traditional healers in the HIV/STI management with a focus on risk practices in Fortaleza, Brazil. This study differs from the others in that the trainers in this study were themselves Umbanda healers who had participated in extensive training. In this study 126 traditional healers were selected for the intervention condition and 100 for the control condition. The intervention focused on safe sex practices, avoidance of ritual blood behaviours and sterilization of cutting instruments. The impact of the training was assessed within 3 weeks following the session, using an orally administered questionnaire.

The fourth study (Wellington, Chingono, Rusakaniko, & Willms, 1997), for which we are also awaiting more information, was a controlled before and after study (CBA) using a quasi-experimental intervention design. 14 districts in Zimbabwe were randomly assigned to either an intervention or control condition. Although 261 traditional healers participated in the study by completing pre and post tests, it is not clear how many healers were allocated to each group. This unpublished study investigated the effectiveness of a 4 day training program designed to alter knowledge, attitudes, and the potentially harmful treatment practices of traditional healers. Traditional healers in both conditions were surveyed prior to the intervention and 6 months following the training.

5.3.3 Risk of Bias in Included Studies

Both of the included studies have been rated as being of low quality and prone to systematic bias (see Appendix 3 for quality assessment of included studies) Furthermore, the power to detect an effect in one of the studies (Poudyal et al., 2003) is limited, given its small sample.

5.3.4 Effects of Interventions

Peltzer et al. (2006) reported a statistically significant increase in HIV/AIDS knowledge ($F = 8.09$, $p < 0.01$) and improvement in HIV/STI patient management practices amongst traditional healers following the training program ($F = 17.43$, $p < 0.01$). However, there was no evidence of differences in the incidence of HIV/STI risk practices ($F = 4.25$, NS, p = NS) between the experimental and control conditions after training.

Poudyal et al. (2003) described a significant increase in knowledge of how to prevent HIV/AIDS ($p<0.001$) as well as its signs and symptoms ($p<0.001$) after training. Furthermore, almost all of the trained traditional healers (92%) had referred patients to Western healthcare professionals when there own methods were not proving effective, whereas only 70% of the untrained traditional healers had done so ($p < 0.05$).

5.5 Discussion

This review of HIV training interventions aimed at traditional healers located 2 eligible studies. Unfortunately methodological heterogeneity, small samples and the risk of biased results limit the conclusions that can be drawn from these studies. .

The two included studies reported positive outcomes for knowledge of HIV and STIs. However, the type of knowledge assessed varied between the studies. Peltzer et al. (2006) utilized a structured scale of 13 items to measure HIV knowledge focusing on major HIV transmission routes, prevention methods and ARV treatment. Poudyal et al., (2003), on the other hand, employed an open-ended questionnaire as a measure of knowledge gain. For example knowledge of the prevention of HIV was assessed in Poudyal et al. (2003) by asking the healer "How can people prevent them from infection of HIV/AIDS"". The traditional healer was correct if they mentioned 2 of the following: a. Stopping having sex with many partners b. Safe sex practice c. Not receiving HIV infected blood transfusion d. Not using un-sterilized syringes and needles. Although it is promising that both included studies reported a positive impact on knowledge gain, there is a wealth of literature demonstrating the increased knowledge of health practices does not necessarily equate to behaviour change (Azjen, 1991). Thus, Peltzer et al. (2006) reported that training resulted in greater knowledge of HIV/AIDS, but at the same time was not able to find evidence for a reduction of HIV/STI risk behaviours.

Although the findings of the studies included in this review indicate that educational interventions may be effective in educating traditional healers in the fundamentals of STI and HIV medicine, their efficacy remains unclear at this time partly due to the methodological heterogeneity amongst the studies in relation to the length and format of the educational intervention. The study conducted by Peltzer et al. (2006) consisted of a 3.5 day workshop, with post-assessment occurring 6-7 months following the intervention. In Poudyal et al, (2003) the duration of the workshop was 7 days, and the post-assessment was not until a year following the intervention. In addition, the training programs in the two included studies provided information on other health problems besides HIV and AIDS. The program described in Peltzer et al. (2006) included a training session on tuberculosis, while Poudyal et al. (2003) focused on a variety of other common illnesses including malnutrition, acute respiratory infection, diarrhoea, night blindness

It is important to acknowledge criticism of current collaborative efforts involving Western and traditional practitioners as adopting a unidirectional and paternalistic approach to health education (Wreford, 2005a). A forum to facilitate input from other stakeholders (traditional healers, consumers) will have to be established in order for this process to be truly collaborative, and ultimately successful. Measures will also have to be taken to protect traditional healer patients, not only through standards and regulations ensuring that traditional

healers are qualified, but also through compliance with evidence-based practices in ensuring the efficacy and safety of their medicines as well.

Although the studies included in this review reported a range of positive outcomes, the small number of studies, combined with heterogeneity of interventions, means it is not possible to draw generalizable inferences about the effects of these interventions. Despite marking a step forward in beginning to establish an evidence base for traditional healer interventions, more rigorous research (those employing RCTs, CBA, or ITS designs) is needed to demonstrate evidence of the impact of this type of intervention on professional practice or healthcare outcomes or both.

Although numerous studies have been conducted assessing HIV/AIDS interventions aimed at traditional healers, only 4 were randomized control trials. Future randomised controlled studies explicitly focused on interventions with rigorous randomisation procedures and allocation concealment, larger sample sizes, and more appropriate control groups, would improve the evidence base for interventions aimed at traditional healer in HIV/AIDS medicine. Furthermore, a systematic review assessing interventions for educating traditional healers not just about HIV/AIDS, but about all Western health care practices, would be beneficial, including mental health.

Although future interventions aimed at traditional healers should attempt to include all of these things, designing interventions that are theory based can assist with identifying the determinants of a particular behaviour, which is imperative when developing interventions. Especially since interventions that address these determinants are more likely to be effective (Bartholomew, Parcel, Kok, & Gottlieb, 2001). The next chapter will investigate the beliefs and attitudes associated with traditional healers and their decision to refer mentally ill patients to a Western practitioner.

CHAPTER 6

PREDICTING REFERRAL PRACTICES OF TRADITIONAL HEALERS OF THEIR MENTALLY ILL ADULT AND ADOLESCENT PATIENTS: AN APPLICATION OF THE THEORY OF PLANNED BEHAVIOUR

6.1 Background

The last research question proposed in Chapter One, was to determine the beliefs and attitudes associated with traditional healers and their decision to refer their mentally ill patients to Western practitioners should their patients not respond to their traditional treatment. The Literature review (Chapter 2) provides more detail on traditional healer referral practices (pg. 48), and the Theory of Planned Behaviour (TPB) (pg. 74). A brief summary follows.

Despite the varying views on collaboration between Western and traditional medicine, South Africa has moved towards officially recognizing traditional healers. The South African government has recently passed the Traditional Health Practitioners Bill and published a draft national policy on African Traditional Medicine (ATM). The policy advocates for Western and traditional medicine to function side by side within the primary health care system and not the integration of the two systems (DOH, 2008).

If Western and traditional medicine practitioners are to work side by side, collaboration in the form of referral is essential. Although studies investigating some medical conditions such as hearing impairment (De Andrade & Ross, 2005), HIV and AIDS (Okome-Nkoumou et al., 2005; Peltzer et al., 2006), TB (Barker et al., 2006), and malaria (Okeke et al., 2006) report that traditional healers are willing to collaborate with Western practitioners and report referring patients, none of these studies focuses specifically on mental health. However, willingness to collaborate does not necessarily equate to referral of patients (Peltzer et al., 2006). Therefore, despite traditional healers' apparent willingness to collaborate with Western medicine and reports of referral, consulting with a traditional healer has been found to result in a delay in receiving essential Western treatment (Barker et al., 2006; Okeke et al., 2006).

Identifying factors associated with traditional healer referral in regard to mental health patients is important for developing and designing interventions to ensure traditional healers refer more frequently and appropriately. Also, the timing of investigating the referral practices of traditional healers proves useful given the passing of the Traditional Health Practitioners Bill and the draft Traditional Medicine Policy. Behavioural theories can assist with

identifying the determinants of a behaviour which is imperative when developing interventions, since interventions that address these determinants are more likely to be effective (Bartholomew et al., 2000).

Given the obvious significance of attitudinal factors when addressing the concept of referral, the Theory of Planned Behaviour (TPB) may be a useful theoretical framework to address this issue. This theoretical model (described in detail in Chapter 2) predicts cognitive variables that influence intention to perform a particular behaviour; it recognises attitudes, perceived subjective norms and perceived behavioural controls as influences on behaviour.

However, there is a great deal of debate in the literature addressing the actual applicability of the TPB with regard to intention being the antecedent of behaviour. Studies that investigated the robustness of the intention-behaviour relationship indicate that a significant gap exists between behavioural intention and behaviour (Albarracin et al, 2001), often being referred to as the "Intention Behaviour Gap". Further understanding of the role of intention as an antecedent to behaviour is essential. Therefore, in spite of broad support for the TPB, it has been argued that it might be possible to increase the predictive power of the model by incorporating additional variables (Conner & Armitage, 1998).

As described in Chapter 2, some researchers have argued for the inclusion of past behaviour in the model (Bagozzi et al., 1992l Sutton, 1994). Additionally, previous studies have included constructs from Bandura's Social Cognitive Theory (Bandura, 1977) as moderators between intention and behaviour (eg. Aaro et al., 2006). These constructs included skills/knowledge and environmental conditions (barriers).

To date, no studies have applied the TPB to predicting traditional healer practices. Therefore, the present study sought to:

1. Apply the basic constructs of the TPB to predict traditional healer referral practices, specifically for mentally ill patients.
2. Apply the extended version of the TPB, containing separate measures of knowledge and past behaviour to the prediction of traditional healer referral practices, specifically for mentally ill patients.

This study was conducted in two phases. Phase One will now be described.

6.2 Phase 1

Phase 1 was an exploratory qualitative study designed to gain an understanding of how traditional healers reach a decision to refer adolescent and adult patients suffering from a mental illness to Western health professionals. In this phase the components of the TPB were examined including common beliefs about referring, advantages and barriers to referring, and groups or institutions that would influence their decision to refer their patients. The information gained from this phase were used to develop the indirect measures of attitude, subjective norm and perceived behavioural control in the next phase of the study.

6.2.1 Methods

Setting

As described in Chapter Two, SADAG is a mental health advocacy group presently active in South Africa. Over the past 4 years SADAG has made efforts to increase the mental health literacy of traditional healers through educational workshops. The aims of these workshops are to: (1) educate traditional healers on the nature of mental illness; (2) educate traditional healers on the signs and symptoms of depression; (3) provide information on traditional or psychiatric treatments available to help people suffering from depression; and (4) encourage traditional healers to refer their mentally ill patients to a Western doctor if they are not responding to traditional treatment. For this study, a convenience sample of 24 traditional healers was selected from those who attended the workshop conducted by SADAG in the Eastern Cape. Traditional healers who practice in three villages in Queenstown, Eastern Cape (Illinge, Whittlesea, Hewu), partook in SADAG's training in June, 2007. According to the 2001 census, Queenstown has a population of 184 591 people. The city itself is home to a commercial, educational and administrative centre for a flourishing farming district.

Participants

All traditional healers who participated in the study were members of the Traditional Healers Organization (THO) and work closely with two non-profit organizations: Africare, a leading non-profit organization that specializes in aid to Africa, and the South African Depression & Anxiety Group (SADAG).

Procedure

Three focus groups were conducted prior to SADAG's workshop in the community hall located in Whittlesea. The focus groups were conducted by the main researcher (KS) with the help of a Xhosa-speaking translator. An open-ended semi-structured interview designed to investigate into the constructs of the TPB allowed the researcher the flexibility to explore particularly interesting themes that materialized and at the same time allowed the group to provide further specifics of a particular issue. This qualitative research approach, using focus groups, provided a means for understanding the complex behaviours surrounding traditional healer referral and allowed for the exploration of the degree of consensus among groups. All participants provided written informed consent prior to inclusion in the study. All focus groups were conducted in Xhosa. All discussions were recorded and transcribed in Xhosa and then translated into English for analysis. Ethics approval for the project was provided by the Research Ethics Committee, Faculty of Health Sciences, University of Cape Town.

Analysis of Data

Although the analysis was guided by the constructs of the TPB, the qualitative data analysis for this study was conducted using the framework approach (familiarization, identifying a thematic framework, indexing, charting, mapping and interpretation). Initially, focus group responses were read for emergent themes, which were then coded. Care was taken to ensure the codes accurately captured the respondent's meaning. A second researcher independently coded the interviews to ensure validity of the categories. NVivo 7.0, a qualitative software program was used for data analysis (QSR international, 2007).

6.2.2 Results

Results are presented in accordance with the aims of this study, which include obtaining information on the constructs of the TPB. Results are divided into: (a) characteristics of traditional healers; (b) views on collaboration with Western practitioners; (c) traditional healer knowledge of mental illness; (d) advantages and disadvantages of referring a mentally ill patient to a Western practitioner; (e) subjective norms (f) perceived behavioural control.

Characteristics of traditional healers

Table 1 summarizes the characteristics of the traditional healers interviewed for this study. The majority of the traditional healers interviewed were women (78%), with an average age of 40 (SD = 0.47) years. Among the healers interviewed, the average education level was standard 5 (SD = 2.8), equivalent to seven years of schooling. Their mean duration of

practicing as a traditional healer was 8 years (range: 1-25 years), with an average length of training of 5 years. A majority of the healers in this study can be classified as Igqirha (90%) (those who have diagnostic powers), while a minority can be classified as ixhele (4%) (those who dispense herbal medicines). Six percent of the participants described themselves as being both a diviner and herbalist. Additionally, all of the traditional healers were members of the Traditional Healers Organization (THO). Furthermore, the traditional healers reported consulting with approximately 7 patients per week.

Table 6.1 Socio-demographic and practice characteristics of traditional healers (N=24)

Characteristic	
Gender (%)	
Male	27
Type of Healer (%)	
Inyanga	4
Sangoma	90
Faith Healer/Sangoma	6
Age in years (mean, sd)	40 (0.47)
Years of education (mean, sd)	6 (13)
Duration of training in years(mean, sd)	5 (2.8)
Duration of practice in years (mean, sd)	7 (0.21)
Number of patients per week (mean, sd)	9 (0.21)

Views on collaboration with Western practitioners

Almost all the healers reported a desire to collaborate with Western doctors (88%), but many noted that this was not occurring. This willingness and desire to collaborate with Western doctors is highlighted in the following statement by a traditional healer:

> *"We want to collaborate with Western doctors. We haven't been brought together here in the Eastern Cape- that's with the presence of both parties. We are pleading with government to bring traditional healers closer to the Western doctors because the constitution allows us to be but at the moment we are still far from that. There are certain ailments that we as Xhosa healers cannot reach. We are eager to work with them, a lot.*

Many healers believe that Western doctors often report to the public and to the media that collaboration is common between traditional and Western doctors, because this is what is supposed to be occurring. However, according to the healers, in reality the Western doctors do not want to work with traditional healers because they do not view them as effective and

valuable health professionals. This viewpoint was encapsulated in the words of one participant who stated:

> *"We are trying to work with them but we haven't been accepted. The western doctors say people should not use traditional healers, because they themselves don't want to understand us. They really don't want us. They just spread it in the media they want to work with us, but they don't. There's still a lot of work to be done. However, we as traditional healers are saying that we are trained. We are not like the healers of long ago, we have been trained. When we collaborate with them they'll see that we are trained- traditionally*".

Among the few traditional healers that were against collaboration with Western medicine, they all considered themselves to be herbalists (12%). The main reason for an unwillingness to collaborate was the belief in the efficacy of their practices and the ineffectiveness of Western medicine to cure patients. This point of view is illustrated by one herbalist who said:

> *"Why would I want to work with Western doctors? We do completely different things. In mental health I am the specialist. I have been curing for years, it is what I do. Not the Western doctors, they can not cure. Sending patients would be a big waste. My patient would not be happy and would think I was a bad doctor"*

When discussing collaboration, many healers reported a desire to work side by side with Western doctors in hospitals and clinics. Many believed that if they were members of the Traditional Healers Organization this would be an attainable goal in time. Furthermore, when addressing the issue of referral, many traditional healers reported that first preference is often given to fellow healers (56%). Often referrals are made to a more powerful healer or one who has access to different or better quality ingredients to make the 'muti'. Traditional healers in the present study expressed the view that Western health care personnel harboured feelings of mistrust towards traditional healers and were reluctant to form a partnership.

Traditional Healer Knowledge of Mental Illness

According to the traditional healers that participated in the focus groups, non-extreme forms of mental illness are not identified as a mental disorder (96%). The healers reported that a patient was only mentally ill if they displayed extreme abnormal behaviour and episodes of violence. Comments reflecting this included:

"The person does funny things, they will hit people, they will make rash silly decisions, and they tend to be very violent. The physical signs are small sometimes they can act like a child and if you take them away from what they were busy with they can throw tantrums. They lose weight and do not bath, they often smell and can become violent"

"I know of a person who was mentally ill and used to hide in a wardrobe. They became quiet timid and they don't take baths, they laugh non-stop and laugh at things that aren't funny. They get lost a lot too. They don't answer questions properly and they also lose weight"

Although a number of causes of mental illness were provided, a majority of the responses pointed to bewitchment. For example, *amafufunyana,* a cultural bound illness described among Zulus and Xhosas is contracted when witches hired by envious people make a 'muti' or poison from a mixture of soil and ants from the grave which is then placed so that the victim may step over it or ingest it. The result of this is that they have dirty things in their heads, which forces them to act crazy and often they become very dizzy. Furthermore, a few healers mentioned severe drug use as a cause of mental illness, while others believed that on occasion an individual can be born with a mental illness.

Advantages and Disadvantages of Referring a Patient to Western Practitioner

According to the traditional healers the few advantages of referring mentally ill patients to Western doctors focussed on treatments that were not always specific to psychiatry. Firstly, it was frequently reported that mentally ill patients are often violent, aggressive, and destructive (90%). This was believed to hinder the ability of the patient to take the medication prescribed by the healer. According to the healers, Western doctors are in possession of an injection that calms patients down, allowing for the traditional healer to administer '*muti*' which has the capability of healing the patient of their mental illness. The 10% of healers who claimed that Western medicine is not useful for calming patients down reported having their own medications to pacify the patient. The efficacy of Western medicine's "injection" is illustrated by healers who said:

"The western doctor can help a patient who is acting very violently and throwing all these things around to make them calm down but that is only temporary".

"Western doctors help with that injection that pacifies even a violent mentally ill person. That person becomes numb and lifeless. That is all they can do. They cannot heal other things. If we were trained we could do that too!"

Secondly, a majority of healers reported difficulty in providing treatment to patients who were weak and dehydrated. It is believed that Western doctors have the technology to provide nourishment to the patient through "a drip" and various other pieces of equipment that are not accessible to the traditional healer (94%). Once the patients are strong, traditional healers are able to treat the patient and in time he or she will be cured from this mental illness. It appears traditional healers are making a catalogue of interventions (injections, drips), which appeal to them and which they are unable to do. However, it was noted that healers would like to be trained to able to use these kinds of equipment. Comments made with regards to the advantage of this Western technology include:

"Western doctors help us a lot when a patient is weak, dehydrated and so on. They help us by putting the patient on a drip. Only then can the patient return to us stronger. Our medicines will then cure the patient. Our medicine is too strong to work on patients who are weak. If you are weak you won't survive taking it".

"Another thing white doctors can do is hydrating a patient with drips. We as traditional healers can't use the drip. They are a great to calm mentally ill. They can be so violent and if they are strong it is very difficult. Western doctors can help on that side of things".

Thirdly, although not as frequently expressed as the advantages listed above, a number of traditional healers reported that if a patient was suffering from a mental illness NOT caused by bewitchment, a Western doctor may be able to cure the illness. According to the healers, mental illness of this kind (either born with or caused by drug intake) is not as common as a mental illness caused by bewitchment. This belief is illustrated by one healer who said:

"A person can be born with a mental illness, like if the mother has it. They could have it too. Western doctors can help with those sorts of problem. We can't help if a person is born with such illness. I think western doctors help a lot there. We can't transplant organs, so if a person has a heart or liver problem, we can't transplant it. We accept

that we don't know and can't do that. We are expert in anything traditional, caused by African reasons.

Finally, a few healers were of the opinion that if their mentally ill patients do not respond to treatment a Western doctor might be useful to obtain a second opinion, as illustrated by one healer who said:

"It is always good to get a second opinion from another doctor. It allows both kinds of doctors to work together. You can't let a person die based on peoples' ego. It is important that you must not be jealous or angry, you must take a patient you can't heal to a doctor who can".

On the other hand, traditional healers reported a number of disadvantages of Western medicine. To begin with, many traditional healers discussed the inability of Western medicine to cure mentally ill patients (79%). Most healers claimed that the only benefits of referring a mentally ill patient to a Western doctor were to receive the injection and the drip. Referring them for any other reason was useless and a waste of time, as Western medicine is unable to cure mentally ill patients. Examples of traditional healers' statements reflecting this theme included:

"The western doctor can help a patient who is acting very violently and throwing all these things around to make them calm down but that is only temporary. Western doctors can not cure a mental illness. They only help some symptoms. If a mentally ill patients gets treatment from a Western doctor they may never be cured. A person has been bewitched the Xhosa way. So this "thing" must be taken out the Xhosa way, you see. Sometimes "izintianga" or "fufunyane" A western doctor won't help, he'll merely pacify him"

"Western doctors cannot heal, following traditional rituals of that person. Mental illness also wants to be healed in a traditional ritual which Western doctors cannot do. We can see the bewitchment inside the patient and take it out. We have people around us that others can never see- the ancestors. They direct us and tell us how to heal patients"

Secondly, it was reported that Western medicine has side effects that can potentially harm the patient. This was usually in contrast to traditional medicines that are believed to have no side effects. Western medicine prepares medication in large quantities and is therefore NOT prepared individually to meet the needs of each patient, as is done in traditional medicine; this results in harmful side effects. A comment reflecting this belief included:

> *"Western meds have side effects. They can make patients very sick. People feel even worse then they did when they were really sick. Xhosa medication does not have side effects, nothing at all. They only bring people back to health"*

Finally, it was evident that traditional healers felt that Western doctors do not have the time to give the patients the attention they need. They are placed in a room with numerous other patients and their individual requirements are rarely reached. This is in comparison to the traditional healer who is available 24 hours a day, 7 days a week, and often checks on the patient regularly to ensure the patient is adhering to the *muti*, and that the patient's family is coping with the patient's needs. One healer recounted:

> *"There are nurses in the hospitals; you'll find three or four nurses in a hospital. That person lying in bed needs incredible attention. They need care and affection. We know that does not happen in hospitals. As the Eastern Cape traditional healer we say, appealing to docs that patients must be treated with love, that gives them hope and they are able to go on"*

Subjective Norms

A few organizations and groups were acknowledged during the focus group discussions for encouraging traditional healers to refer their patients to a Western doctor if they were not responding to traditional treatment. For example, the Traditional Healers Organization (THO) the largest formation of traditional healers in the country, are recognized by the government as professional specialists, promoting quality indigenous systems of health care in the rural areas, and which is reported to encourage traditional healers to collaborate with Western doctors through referral. This is also the organization that is playing a key role in the Traditional Health Practitioners Bill, which, if implemented effectively, requires traditional healer referral.

In addition, Africare, an American non-profit organization working in partnership with African communities to achieve healthy and productive societies, encourages traditional healers to refer patients if they are not responding to treatment. It was mentioned that Africare has also provided them with formal referral forms, allowing them to come across in a professional manner when working with their Western professional counterparts.

> *"Africare has worked with us lots to train us to provide better services to our patients. They talk about cleanliness and train us on HIV and AIDS, which is important. They want us to refer our patients to Western doctors. They even gave us professional referral forms".*

The mentally ill patient's family was also reported to have an influence on the referral practices of traditional healers. A few of the healers mentioned that the patient's family would like the healer to refer the patient to a Western doctor if they are not responding to treatment. However, other healers claimed that the patient's family plays more of a passive role in the patient's health, conforming to the requests of the traditional healers.

Although not frequently mentioned during the focus group discussions, the influence of churches on traditional healer practices was highlighted. A majority of the healers reported good working relationships with churches in their areas. However, according to the healers, there are a few churches that are against their practices altogether, and advise that community members NOT to consult with traditional healers. This is explicated by one traditional healer:

> *"There are certain churches in the community that will not let us work with them or their people. They really do not like us. Some of the younger people were also opposed to our practices. I suppose it did not go with what they see on TV"*

Perceived Behavioural Control

When questioning the traditional healers about the factors or circumstances that make it difficult for them to refer their mentally ill patients, the present attitudes of Western doctors towards traditional healers and their practices was a common theme. To begin with, almost all the traditional healers interviewed discussed concerns over the lack of respect they receive from Western practitioners.

"Western doctors do not respect traditional healers. They do not believe we are doctors even. They think we are stupid and are unable to heal anyone. They think patients should not come see us cause we are unable to help them. This is not true"

Along similar lines, the common belief that Western doctors do not approve of traditional healers also emerged. Allegedly, Western doctors do not believe that the herbal medicines prescribed by traditional healers are effective and believe they are a waste of both money and time for the patients.

"It happens often that someone goes to a western doctor and they ask him what they have done or if they have seen anyone else before, and if they say that they were using Xhosa medicine, they say 'this is what made you worse' and it's not it. Some don't like us and they don't welcome our working together with them"

"They say we don't even measure our medicine correctly. This is wrong. We are directed by ancestors on how to administer medicine. They say our medicine is too strong. We give our patients exactly what they need. We can't treat patients the "right way".

Finally, a number of the healers discussed their experiences of getting blamed if a patient who had consulted with them previously died. This is despite the patient consulting with a Western doctor in order to get better and still did not survive. Traditional healers believe that Western doctors blame them when a patient dies, even if the death could have been caused by a number of other factors, including treatment provided by a Western doctor.

"They don't trust our judgment. They think no one knows more than they do. A doctor gave another guy sleeping pills, he got home and slept and the family realized after a while that the person had died in his sleep. Now tell me what would have happened had it been a traditional healer that gave the man sleeping tablets? They would say you killed him. There was no complaint to the western doctors that he gave out sleeping pills but the person never wakes up"

"So we have a problem that anytime a person goes to a Western doctor having first come to us they say it is our fault. Even when a person dies, the blame is put on us-

keeping in mind that people who are operated on sometimes die because of the operation. But if we dare not heal a patient to perfect health, we are condemned"

6.2.3 Discussion

The main results of this phase of the study are that 1) traditional healers do have a concept of mental illness which includes a patient behaving abnormally and often report regularly treating patients suffering from this; 2) traditional healer referral to Western care is considered a temporary measure or as a last resort, a view that is not necessarily specific to psychiatry; 3) traditional healers feel that Western doctors do not treat traditional healers with the respect that they feel their contribution to the health of the community warrants.

The finding that traditional healers identify a mentally ill patient through extremely abnormal behaviour and episodes of violence is consistent with previous studies in this area (Aidoo & Harpham, 2001; Patel et al., 1995b). For example, a study utilizing 9 focus group discussions consisting of 76 care workers (30 community workers, 22 traditional healers, 15 relatives of patients and 9 psychiatric nurses) was conducted in Zimbabwe, to elicit information on concepts of mental illness. Results indicated that participants were able to identify a mentally ill patient by their behaviours. For example, wandering away from home, eating or smearing faeces and laughing at inappropriate times were reported to be common behaviours of a mentally ill patient. In addition, impaired self-care such as not washing or eating dirty food was noted. One of the major problems with a view that equates a psychiatric disorder with serious behavioural disturbance is reinforcing the stigma attached to mental illness. Stigma may be preventing many South Africans from seeking appropriate treatment when mental health difficulties are first experienced. This is a serious problem considering early identification and treatment is generally associated with better outcomes (Corrigan & Matthews, 2003)

Particularly striking is that traditional healers report that the main advantages of Western psychiatric medicine are not always specific to psychiatry, and view the treatments provided not as a cure, but as a temporary measure. It appears that Western medicine is essentially viewed as a viable option under extreme circumstances when patients show signs of excessive violence or dehydration. Western medicine is reported to be valuable for giving patients the strength to allow the traditional healer to successfully administer the "muti". This addresses the question of why traditional healers have shown a willingness to collaborate with Western

medicine (Green & Makubu, 1984; Peltzer et al., 2006), even though they may not always consider Western practices effective or even safe.

However, one indication for referral was that traditional healers believed Western doctors were capable of curing patients who suffer from a mental illness NOT caused by bewitchment (for example, those born with illness, or suffering from an illness caused by alcohol or other substance use). However, it is the traditional healer that diagnoses the 'cause' of the mental illness and most of the healers reported the main cause of mental illness to be a result of witchcraft or bewitchment. This finding is broadly consistent with existing literature on the distinction between what was referred to as "natural" and "supernatural" causes of mental illness (Crawford & Lipsedge, 2004; Ngubane, 1977). "Natural" causes of mental illness are reported to be present at birth (epilepsy/mental retardation), and Western health professionals are believed to be capable of understanding and treating these kinds of "natural" illnesses. On the other hand "supernatural" illnesses are believed to be understood within the African concepts of illness and therefore only recognized and treated by traditional healers. However, distinguishing these two types of mental illnesses is unlikely to be a straightforward process.

The finding that traditional healers reported that Western doctors do not respect them or their practices, and often get blamed if a patient dies, is consistent with previous literature in Africa. For example, in a survey conducted with Nigerian doctors reported that a majority of the physicians were willing to work with traditional healers (88%), however 76% of the participants interviewed reported that they would never refer patients to a traditional healer for treatment (Ojanuga, 1981). This belief is also congruent with the strong opinion voiced by Doctors for Life, who believe that "any form of medicine that is not based on empiric truth is potentially (and ultimately) harmful to patients in need", and are against the regulation of traditional healers in South Africa since it would be illogical to regulate the use of traditional medicines since they have been validated scientifically (Doctors for Life, 2007)

The results of the present study have a number of implications. The first is the need to educate traditional healers about mental illness and when to refer severe mentally ill patients to Western health professional. The findings of this study indicate that some traditional healers would not refer patients to a health facility because they believed in the efficacy of their herbal remedies and the ineffectiveness of Western medicine to cure this illness. It is only when patients showed signs of extreme violent behaviour that they would refer them to Western professionals. However, the effectiveness of traditional practices in

regard to any mental illness has not yet been established scientifically. Some traditional healers reported referring patients that did not respond to their treatment to either a health facility or another traditional healer. However, this would usually occur after several stages of traditional herbal remedies, thereby resulting in long delays before potentially appropriate treatment is received. Although not specifically aimed at mental health, studies have shown that treatment delay in receiving essential biomedical treatment resulting from consultation with a traditional healer can have dire consequences for the patient (Barker et al., 2006; Okeke et al., 2006).

Severe mental disorders, such as schizophrenia, are potentially life threatening, and may affect many aspects of a persons life and general health, and is often reported as being closely linked to suicide (McGirr, Paris, Lesage, Renaud, & Turecki, G, 2007). According to Meltzer (1998), the rate of suicide attempts in schizophrenia patients is reported to lie between 20–40%. However, clinical trials have demonstrated the efficacy and cost-effectiveness of locally feasible treatment for a number of mental illnesses, including more severe psychiatric disorders (Chatterjee, Patel, Chatterjee, & Weiss, 2003). Therefore, at the moment, one could view consulting a traditional healer as a barrier to receiving appropriate mental healthcare. Especially since according to the healers in this study, disorders such as depression and anxiety do not appear to fit under the category of mental illness. However, organized and well trained, traditional healers have the potential to be a significant treatment and referral resource for mentally ill South Africans.

Secondly, there is a need for dialogue between traditional and Western practitioners in regard to mental health care. The mutual lack of trust, respect and understanding between Western and traditional medicine is situated within the context of the ongoing debate within the South African mental health literature as to whether, or in what form, traditional healers should collaborate with mental health practitioners in the formal mental healthcare sector. As described in the previous chapter (Chapter 5), traditional healers have been involved in a number of training programs, predominantly around the issue of HIV and AIDS programs (Green 1994; Green et al., 1995; UNAIDS, 2000). This current collaborative effort takes on the form of a one-sided unidirectional, educative approach, with an emphasis on training traditional healers. However, what remains to be determined is whether or not these efforts are effective. This is due to collaborative projects being small-scale, short term, lacking national co-ordination (Devenish, 2005) and more importantly proper evaluation including constructs such as attitude and behaviour change (see Chapter 5). The literature often reports

distrust and scepticism from Western doctors towards traditional healers, but the results of the present study reveal that these feelings may not only be one-sided. Furthermore, in order to foster an understanding of each other's potential contribution in treating the patient physically and spiritually, it may be helpful for traditional healers and modern health care practitioners to meet in forums where they can both exchange knowledge and discuss what each group hopes to gain from collaborating. These factors assume particular significance given the recent promulgation of the Traditional Health Practitioners' Bill that seeks to make traditional healing part of the formal health care system in South Africa.

Thirdly, although more formal testing is required, the results of this exploratory study show the potential for the TPB to be a useful model in predicting the referral practices of traditional healers. The TPB has been widely used to explore factors associated with health professionals' beliefs and attitudes to health-related behaviour (Limbert & Lamb, 2002; McCarty et al., 2001; Walker, Grimshaw, & Armstrong 2001), although only a few have utilized the TPB to address referral practices of health care professionals (Conner & Heywood-Everett, 1998; Millstein, 1996).

Several limitations of this study must be considered when interpreting these findings. Firstly, as this was a qualitative study that utilized a convenience sample of traditional healers from the Eastern Cape, the results cannot be generalized to the South African traditional healer population. Some of the traditional healer practices and beliefs may differ across provinces. Secondly, since this study was conducted in a foreign language in which the principle investigator is not fluent is another weakness of the study. Even though the interview schedule was translated from English to Xhosa and the responses translated back to English, some of the constructs and concepts may have been difficult to translate between languages. Finally, the possibility of respondents perceiving the researcher as an outsider could have effected the findings.

The findings of this qualitative study were used to develop the indirect measures of attitude, subjective norms and perceived behavioural control in Phase 2 of this study.

6.3 Phase 2

6.3.1 Methods

Participants

The study population included traditional healers who practice in the Queenstown area of the Eastern Cape Province. According to the 2001 census, Queenstown has a population of 184 591 people. The city itself is home to a commercial, educational and administrative centre for a flourishing farming district. Specific villages included: Queenstown, Ezibeleni, Ilinge, Machibini, Poplar Groove, Braakloof, Tambo, Mc Bride, Who can tell, Long Draai, Galla Water, Sada (Upper & Lower Shiloh), Ekuphumleni, Emtha, Whittlesea, Hackney, Cimezile, Zweledinga, Musa, Yonda, Oxton, Pricesdale.

Procedure

In order to complete Phase 2 of this study, 4 steps were required.

Step 1- instrument development

The aim of this exploratory qualitative phase is to gain an understanding of how traditional healers reach a decision to refer adolescents and adults patients suffering from a mental illness to Western health professionals. Three focus groups with 24 traditional healers were conducted to elicit the indirect measures of the TPB, including common beliefs about referring, advantages and barriers to referring, and groups or institutions that would influence their decision to refer their patients. The findings of this phase resulted in the construction of questionnaire items relating to behavioural beliefs, normative beliefs, and control beliefs about referral practices and are described above in Phase 1.

Step 2- the pilot

To ensure that the questionnaire was easily understood, of appropriate length and addressed relevant issues involved in traditional healer referral practices, a pilot study with 25 traditional healers was conducted. Anecdotal comments concerning the format and content of the questionnaire were noted and acted upon for the final version. The questionnaire was found to take approximately 25-60 minutes to complete, was easily understandable and was presented in a user-friendly format. In order to assess the test-retest reliability of the indirect

measures, the questionnaire was administered again to the identical 25 traditional healers, with an interval of 8 weeks.

Step 3- administering complete survey

Of the 143 traditional healers who were approached to participate in this final study, only 100 full interviews were conducted. Thirty-nine traditional healers did not work with mentally ill patients while 4 interviews were stopped due to the healers being intoxicated. The study utilized a "snowball" or acquaintance sampling strategy. Traditional healers were asked to provide details of other traditional healers in their village. Interviews were conducted in a variety of locations, ranging from the traditional healers home, the car and traditional healer surgeries. The length of the interviews ranged from 25 minutes to 60 depending on the understanding and speed at which traditional healers answered the specific questions. Although this study was quantitative, one-on-one interviews were conducted due to the low literacy levels of the healers. Prior to the interview, each participant was informed about the confidentiality and anonymity of the process. Participation was voluntary, as was withdrawal from the study. Consent was then obtained for participation in the study.

Step 4- eliciting self-reported behaviour construct

All traditional healers were contacted again 5 months later either by cell phone (79%) or in person to elicit information on their referral practices (21%). This process took 2 weeks as locating traditional healers was a timely process.

Measures

During the exploratory qualitative phase it became apparent that it was regular practice for traditional healers to refer those who are extremely violent and weak (require a drip) to a Western doctor. Therefore, the instrumentation in this study refers to attitudes, subjective norms and beliefs of traditional healers for patients who are not violent or weak.

The final questionnaire contained 63 questions, 8 of which were designed to identify participants' demographic and work characteristics. The next 44 questions were used to assess TPB components, 1 question assessed past behaviour and the remaining 13 items assessed the knowledge of traditional healers specifically in regard to mental illness (See Appendix 4). Wording of items and the extreme labels were varied in direction to reduce the likelihood of

response set. The internal reliability of the scales was assessed by Cronbach's alpha, and scales with values of higher than α=0.60 were considered acceptable.

Attitude

The direct measure of attitude was assessed by taking the mean four responses to the statement, "Referring my mentally ill patient to a Western doctor would be….". This statement was evaluated on 4-point unipolar (+1 to +4) scales with the endpoints: useful/not useful; very wrong/not wrong at all; foolish/not foolish at all; very good/not good at all. The Cronback's alpha for the scale was .83.

Subjective Norm

Perceived social pressure to refer mentally ill patients to a Western doctor if they are not responding to traditional treatment was assessed with a 3 item measure using a 4 point unipolar (+1 to +4) scale: "People who mean a lot to me would like me to refer my mentally ill patients to the Western doctor? (YES-NO)," "Most people who are important to me think that I should refer my patient to a Western doctor (YES-NO)," and "It is expected of me to refer my mentally ill patients to a Western doctor (YES-NO)". The mean of the items made a scale with good internal reliability (Cronbach's α= .90).

Perceived Behavioural Control (PBC)

Items assessing PBC included questions eliciting traditional healers' self-efficacy and their beliefs about the controllability of referring their mentally ill patients to a Western doctor if they are not responding to treatment. Confidence in one's own ability was assessed using the responses to two items: "I am confident that I could refer my mentally ill patients to a Western doctor if I wanted to (YES-NO)", "For me to refer my patients to refer my mentally ill patients to a Western doctor is (very difficult-not difficult at all)". Three items assessed controllability: "Whether I refer my mentally ill patients to a Western doctor is completely up to me (NO-YES)", "Whether you refer your mentally ill patients to a Western doctor is your decision (YES-NO)" and "It is possible for you to refer your mentally ill patient to a Western doctor if you wanted to (YES-NO)". All items were measured using 4 point (+1 to +4) unipolar scales. Cronbach's α indicated moderate reliability for the scale (α= .65).

Behavioural Beliefs

The behavioural belief scale included 7 items on outcome expectancies and 7 corresponding items to measure evaluation of the outcomes. The stem for the behavioural outcome belief items assessed how true the stated outcome of referring a patient to a Western doctor was with responses from 1 (very true) to 4 (not true at all) (e.g. "If I refer my mentally ill patient who is violently ill to a Western doctor they can give them medication to calm them down"). Corresponding outcome evaluation items assessed the value of each outcome, measured on bipolar (-2 to +2) scales (not true at all-very true) (eg. Giving a mentally ill patient medication to calm them down is: Each outcome expectancy score was multiplied by its corresponding outcome evaluation item, and the products were summed for a weighted behavioural belief score, with higher scores indicating more positive behavioural beliefs.

Normative beliefs

The normative belief scale included 3 items on normative belief referents and 3 for the corresponding motivation to comply with the referents. The stem for the normative referents items assessed referents who have a social influence on the respondent (e.g. "Traditional healer groups or institutions such as the Traditional Healers Organization (THO) would like you to refer your mentally ill patients to a Western doctor if they are not responding to treatment"). These measures were assessed using a 4 point (+1 to +4), with responses ranging from Very True to Not True at all. Corresponding items measured the motivation to comply with those referents, which were assessed using 4 point bipolar scales ranging from -2 (not at all) to +2 (very much) (e.g. "Doing what traditional healer groups or institutions such as the THO wants me to do is important to me?"). Each normative referent score was multiplied by its corresponding motivation to comply score, and the products were summed for a weighted normative beliefs score, with higher scores indicating stronger social influence or normative beliefs for referring mentally ill patients.

Control beliefs

The control belief scale included 4 items on control belief factors that may facilitate or impede carrying out the behaviour and 4 corresponding items for control belief power. The stem for the control factor assessed agreement with conditions that would make carrying out referring patients to a Western health care professional difficult or easy (e.g,"Traditional healers often get blamed if a patient dies"), with responses from 1 (not true at all) to 4 (very true). Corresponding items measured the power of the condition to make referring difficult or easy (eg, "When Western doctors blame traditional healers when a patient dies, how difficult is it to refer a patient"), with responses from 1 (very difficult) to 4 (Not difficult at all).

Negative items were reverse-scored. Each control factor score was multiplied by its corresponding power of the factor, and the products were summed for a weighted control belief score. Positive scores indicated stronger belief of control over factors that facilitated or impeded referral practices.

Behavioural Intention

Behavioural intention was measured using a single item question: "How many patients do you expect to refer in the next month that is not violent or weak" (all of them-none of them)".

Past Behaviour

A single item measured traditional healers' past behaviour. The item read: "Have you ever referred a mentally ill patient to a Western doctor who was not violent or weak (requiring injection or a drip)?" Response options were: Yes or No.

Knowledge

A knowledge measure comprising 13 items was developed for the study assessing Western symptoms of mental illness. Questions had 'true', 'false', 'don't know' response options. A scale was computed by taking the sum of all the knowledge indexed items. If a question was answered correctly, the participant scored 1, if incorrect –1, and if they didn't know they scored 0. Thus, potentially, a knowledgeable participant could have a maximum score of 13, if they answered all 13 questions correctly.

Analysis of Data

All data analyses were conducted using SPSS 16.0 with the exception of PATH analyses which were conducted using MPLUS. Although we would have liked to include measurement models in this analysis, in keeping with the methods described by Ajzen (1991), and the relatively small sample size a path analysis was conducted.

Both direct and indirect measures of attitudes, social norms, and perceived behavioural control (PBC), had to be created by aggregating multiple items, inter-item analyses. First, inter-item correlations were assessed. Second, principal components factor analysis with varimax rotation was performed and the resulting factor loadings' matrix was assessed for simple structure. Eigen values were also assessed to ensure the identified factor accounted for

an acceptable amount of variance. Kaiser's measure of sampling adequacy (KMO) was assessed to determine the factorability of the data. Finally, correlations between the belief-based measures (indirect) and the direct measure were then assessed. To control for the potential effects of demographic variables, we used bivariate correlations to examine associations between demographic factors and TPB constructs.

After the total scores were compiled for attitudes, subjective norms and perceived behavioural control; path analyses was conducted on these variables to determine the applicability of the TPB in the referral practices of traditional healers. A number of statistics exist to assess the adequacy of structural models (Bollen, 1989). The most common statistic is the chi-square statistic. However, this test has been criticized as an insufficient test alone to adequately assess model fit, generally because of sample size and power estimation problems or assumptions (Hu & Bentler, 1995). Therefore, the inclusions of absolute and incremental fit indices are recommended (Hu & Bentler, 1999). The chi-square statistic and root mean square error of approximation (RMSEA) was included as an absolute fit index. General rules of thumb for acceptability of model fit using the RMSEA is >0.07 for RMSEA (Hu & Bentler, 1999).

Analyses of TPB measures

Reliability analyses were conducted for each component of the TPB model. Cronbach's alpha was $\alpha = 0.83$ for the attitudes items, $\alpha = 0.90$ for the subjective norms items, $\alpha = 0.60$ for the perceived behavioural control items.

In order to provide evidence for the validity for the TPB measures, bivariate correlations between the four questions measuring direct attitude were high with values ranging from .75 to .85. Principal components factor analysis with varimax rotation indicated the presence of a single factor (eigenvalue = 3.357) with each item having a high factor loading ranging from .885 to.945. The KMO statistic was found to equal .859. Similarly, direct measures of SN resulted in correlations ranging from 0.692 to 0.821. Principal components factor analysis with varimax rotation also indicated the presence of one factor (eigenvalue = 2.525) with each item having a high factor loading ranging from 0.893 to 0.944. On first assessment, principal component factor analysis did not indicate the present of a single factor. However, after the removal of 2 questions "Whether I refer my mentally ill patients to a Western doctor is completely up to me?" and "Whether you refer your MI patients to WD is only your

decision?", the internal reliability increased to α = 0.84. Additionally, principal component factor analysis with varimax rotational indicated the present of one factors (eighenvalue = 2.286). Furthermore, the three remaining items for the PBC items resulted in high factor loadings ranging from 0.774-0.046. Measures of internal reliability and factor analysis are not appropriate for weighted measures of behavioural beliefs, normative beliefs, or control beliefs because they are formative rather than reflective indicators of the underlying construct. See table 6.2 for descriptive statistics for all TPB constructs.

Table 6.2 Means, standard deviations and Cronbach alphas

Measure	No. of Items	Range	Mean	S.D.	Cronbach alpha
Direct Attitude	4	1-4	2.54	1.00	.83
Direct SN	3	1-4	2.47	1.06	.90
Direct PBC	5	1-4	2.860	0.964	.60
Behavioural Beliefs	7	-31 - 34	0.470	13.97	-
Normative Beliefs	3	-16 - 24	4.14	7.68	-
Control Beliefs	11	-28 - 28	0.500	1.064	-
Behavioural Intention	4	1-4	1.79	0.967	-
Past Behaviour	1	1-2	1.4	0.492	-
Knowledge	13	1-5	2.14	1.06	.74

6.3.2 Results

Results are presented in accordance with the aims of this study. Results are divided into: (a) characteristics of traditional healers; (b) applicability of basic constructs of TPB in the referral practices of traditional healers (c) predictability of the modified version of the TPB, including knowledge and past behaviour.

Characteristics of traditional healers

Table 1 summarizes the characteristics of the traditional healers interviewed for this study. The majority of the traditional healers interviewed were women (65%), with an average age of 49 (range 22-79) years. Among the healers interviewed, the average education level was standard 3 (SD = 2.8), equivalent to five years of schooling. Their mean duration of practicing as a traditional healer was 14 years (range: 6 months-45 years), with an average length of training of 4 years. A majority of the healers in this study can be classified as *igqirha* or

diviners (75%) (those who have diagnostic powers), while a minority can be classified as *ixhele* or herbalists (14%) (those who dispense herbal medicines) and faith healers (5%). Six percent of the participants described themselves as being both an igqirha and ixhele (3%), while 3% described themselves as being a combination of all three. Additionally, only 57% of the healers were members of the THO, while 23% did report they were members of an organization, the remainder did not belong to an organization at all. Furthermore, the traditional healers reported consulting with approximately 8 patients per week (ranging from 2-40).

Table 6.3 Socio-demographic and practice characteristics of traditional healers (N=100)

Characteristic	N	%
Gender (%)		
Female	65	65
Type of Healer (%)		
Igqirha (diviner)	75	75
Ixhele (herbalist)	14	14
Abathandazeli (faith healer)	5	5
Igqirha & Ixhele	3	3
Igquirha, Ixhele & Abathandazeli	3	3
Age in years (mean, sd)		49 (13)
Years of education (mean, sd)		3 (2.8)
Duration of training in years(mean, sd)		3 (3.72)
Duration of practice in years (mean, sd)		14 (10)
Number of patients per week (mean, sd)		8 (9.54)

Although there were no significant associations between demographic variables and TPB constructs, the type of traditional healer differed significantly on intention to refer. Ixhele (herbalists) were less likely than the other types of traditional healers to refer their patients to a Western health care professional (χ^2= 3.96, *df*=1 *p*=0.047).

Applicability of the TPB in the referral practices of traditional healers

Basic TPB Model in Predicting Traditional Healer Referral Practices

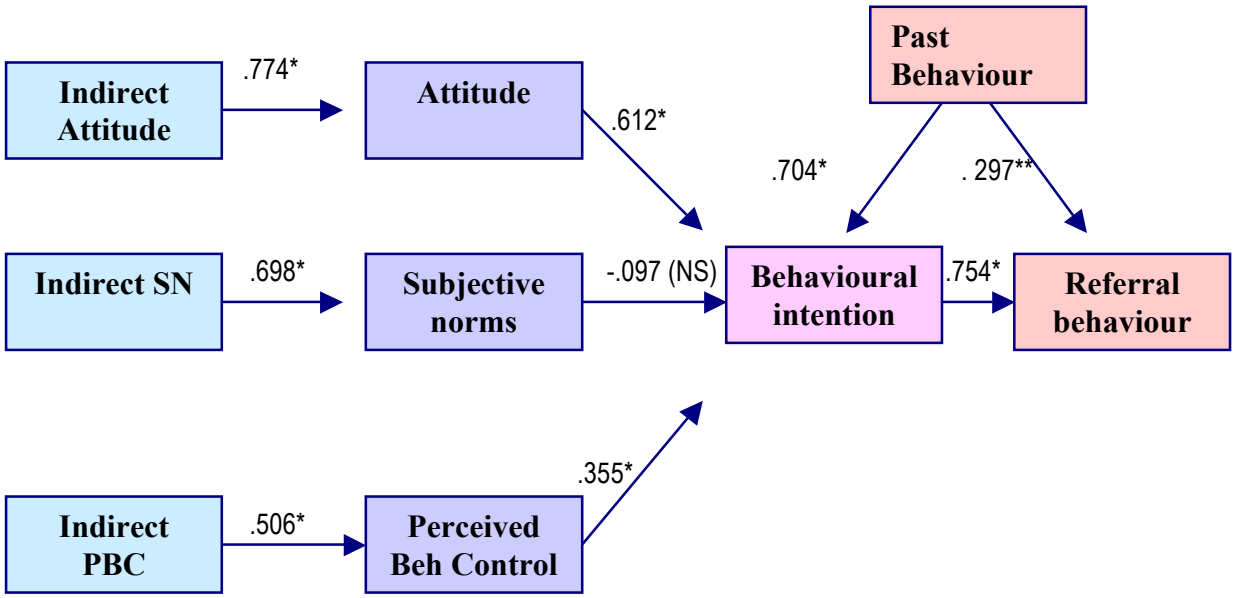
Indirect and direct measure of attitudes and perceived behaviour control toward referring mentally ill patients were moderately correlated (attitude r = .0.774, $p < .001$; PBC 0.698 $p < .001$; SN 0.506 $p < .001$).

Path analysis using MPLUS (Muthen & Muthen, 2007) was used to examine the basic TPB model with respect to the referral practices of traditional healers. The chi-square test of model fit was not significant (χ^2 = 1.247, p = .536) and the RMSEA value was well below the value of .06 (p<0.01) recommended by Hu and Bentler (1999) as an upper boundary, so we can conclude that the proposed model fits the data well. Looking at the individual TPB constructs, more favourable attitudes (ß = 0.548, p< 0.01); and more perceived behavioural control (ß = 0.366, p < 0.01), predicted greater intentions to refer patients to Western healthcare professionals. Contrary to expectations, stronger subjective norms did not predict intentions (ß =0.007, ns). Additionally, stronger intentions to refer patients predicted greater self-reported behaviour (ß = 0.758, p < 0.01).

Modified Version of the TPB

Path analysis was used to examine the basic TPB constructs in addition to two other constructs: Past Behaviour and Knowledge. The chi-square test of model fit is not significant (χ^2 = 3.441, p = . 841) and the RMSEA value is p<0.01. We can conclude that the proposed model fits the data well. Similar to the results in the basic model, attitude (ß = 0.612, p < 0.01),) and perceived behavioural control (ß = 0.355, p < 0.01), significantly predicted intention to refer, while subjective norms did not. (ß = -0.097, *ns*). Although past behaviour was a strong predictor of intentions to refer (ß = 0.704, p < 0.01), and self reported behaviour ß = 0.297, p = 0.040), knowledge was not (ß = 0.249, *ns*). Additionally, stronger intentions to refer patients predicted greater self-reported behaviour (ß = 0.754, p < 0.01). See Figure 6.1.

Figure 6.1 Standardized coefficients estimated in a path model predicting traditional healer referral practice



*p < .01, ** p < .05,

6.3.3 Discussion

The main results of this study are as follows. First, herbalists were less likely than any other type of healer to refer mentally ill patients to Western health professionals. Second, a number of constructs were found to be predictors of traditional healer referral practices. These included attitude, perceived behavioural and past behaviour, and intention to refer. Third, subjective norms and knowledge of mental illness were not predictors of traditional healer referral practices.

The initial finding that diviners are more likely than herbalists to refer mentally ill patients to Western healthcare professionals can be explained by a number of factors. There are many differences between the training and treatment practices of diviners and herbalists. Diviners are predominantly female and are 'called by their ancestors' to the profession (Bürhmann, 1977; Hammonde-Tooke, 1989; Ngubane, 1977; Sweitzer, 1977). Diviners diagnose the patient and establish the cause of the patients' particular problem. Although most diviners are trained in prescribing herbal treatment, others refer them to the "specialists", the herbalists (Gumede, 1980). Herbalists are predominantly male and are comparable to pharmacists in Western medicine. According to Chuvunduka (1994), herbalists do not have to be called to the profession, even though the medicines used are considered to have magical qualities. Of the 14 herbalists who participated in the study, only one was registered with the Traditional Healers Organization (THO). On the other hand, 65% of all diviners were registered. Most of the herbalists reported great faith in the effectiveness of their treatments and therefore any referral would not be appropriate for the patient. Furthermore, the herbalists in the present study voiced serious concern over Western medicine and their motivation for collaboration. Many herbalists were reluctant to collaborate as they believe their herbs would be stolen and used in the mass production of Western medicine. This finding suggests that in order to improve the referral rates of traditional healers, interventions need to take the type of healer into consideration. Interventions that are effective for diviners may not be effective for herbalists.

The findings of the present study show the potential for the TPB to be a useful model in predicting the referral practices of traditional healers. The TPB has been widely used to explore factors associated with health professionals' beliefs and attitudes to health-related behaviour (Limbert & Lamb, 2002; McCarty, Hennrikus, Lando & Vessey, 2001;Walker, Grimshaw & Armstrong 2001), although only a few have utilized the TPB to address referral practices of health care professionals (Conner & Heywood-Everett, 1998; Millstein, 1996). Attitude, perceived behavioural control and past behaviour, were found to significantly predict traditional healer referral practices. Traditional healers' attitudes about Western medicine and their practices were good predictors of intentions. Traditional healers who reported more favourable attitudes towards Western medicine and deemed their practices useful in treating mentally ill patients were more likely to refer their patient. Additionally, traditional healer beliefs about the degree of control they had over referring their patients were good predictors of their intentions. Traditional healers' who believed that they had control over referring, were confident that they could perform the behaviour and perceived that the behaviour would be less difficult to perform, had greater intentions to refer. It is not surprising that past behaviour proved to be a strong predictor of traditional healer referral practices, since its inclusion is often supported in the available literature (Bagozzi, Baumgartner, & Yi, 1992; Sutton, 1994). Those healers that had previously referred a mentally ill patient to a Western doctor were more likely to refer again. Some healers even gave examples of a close working relationship with Western health professionals at their local clinic.

Although some of the constructs in the TPB predicted traditional healer referral practices, subjective norms were not found to be a significant predictor. Therefore, there is not an expectation from the community that they should refer patients. Unlike Western health professionals, traditional healers work rather autonomously. Many of the healers in the present study described stories of envious and jealous healers in the community that try to cause harm to those who are successful. This could be one of the reasons the healers are reluctant to share their information and treatment practices (with the exception of initiates). Additionally, referral could indicate a failure on the part of the traditional healers. At the present time traditional healers do not have a regulatory body governing their practices and treatment methods. Although with the passing of the Traditional Health Practitioners Bill and the draft traditional Medicine policy being developed, it is hoped that this will change. Therefore, at the present time there are no standards of practice for this group of healers, and consequently they are not held responsible for their practices should negative consequences

occur. Ajzen and Fishbein (2003) have noted that due to variations in the behaviour and populations under investigation, it should not be expected that all TPB factors (attitudes, subjective norms and perceived behavioural control) will always be significant. Indeed, several studies have found stronger support for some components of the TPB than others with subjective norms often emerging as the weakest predictor (Armitage & Conner, 2001). For example, a meta-analysis of the TRA reported that subjective norms were the weakest predictor of intentions (Sheppard, Hartwick, & Warshaw, 1988).

Additionally, knowledge was not a predictor of traditional healer referral practices. The available research indicates that traditional healers identify a mentally ill patient through extremely abnormal behaviour and episodes of violence (Patel et al., 1995b; Aidoo & Harpham, 2001). Mufamadi (2001) interviewed 8 traditional healers in Limpopo to investigate how they perceived mental illness, its causes and treatment methods. She found that a number of symptoms were associated with mental illness, including: aggression, talking incoherently, isolation, shouting loudly, confusion and strange behaviour. She also reported perceived causes such as heredity, witchcraft, sorcery, disregard of cultural norms and spirit possession. Even though traditional healers do have a coherent concept of mental illness, it is often equated with more psychotic symptoms such as severe behavioural disturbances (Patel, 2006).Therefore, it may be that the questions used to assess traditional healer knowledge were not appropriate for this population, since their explanatory models of mental illness differ from more Western explanatory models.

The results of the present study have a number of implications. To begin with, the traditional healers in this study appear to have a relatively low level of mental health literacy. Disorders such as depression are generally not identified as a mental illness by traditional healers. Therefore, the findings of this study recommend that traditional healers be adequately trained in mental illness matters. Training and the provision of accurate information are necessary to address the current gaps in knowledge of traditional healers regarding mental illness. Traditional healers may also want to know whether psychiatry contributes anything that service users' value and regard as useful prior to referring patients. Equipping traditional healers to understand and effectively manage mental illness in their communities will contribute towards traditional healer's optimal utilization in their communities. Interventions designed to increase the mental health literacy of traditional healers would be beneficial

Secondly, it was regular practice for all traditional healers to refer their mentally ill patients to a Western healthcare professional if the patient was violent or required a drip because they were too weak. The healers noted that only Western doctors had access to this invaluable equipment. Therefore, mentally ill patients who show signs of extreme violence are coming into contact with a Western healthcare professional. This finding could also be used as a possible window into collaboration between Western and traditional medicine. Additionally, approximately half of the traditional healers in this study reported referring their patients to a health facility if their patients were not responding to their traditional treatment. Although this appears to be good practice, it is not clear that traditional healers have appropriate guidelines on how long they should treat their patients with a mental illness before referring, While not specifically aimed at mental health, studies have shown that treatment delay in receiving essential biomedical treatment resulting from consultation with a traditional healer can have dire consequences for the patient (Okeke et al., 2006; Barker et al., 2006).

Since it was not regular practice for half of the traditional healers in this study to refer their mentally ill patients to a Western doctor if they were not responding to treatment, consulting a traditional healer may be conceptualized as a barrier to receiving appropriate mental healthcare. The main reason for traditional healers not to refer their patients to a health facility was because they believed in the efficacy of their herbal remedies and the ineffectiveness of Western medicine to cure this illness. However, the effectiveness of traditional practices in regard to any mental illness has not yet been established scientifically. Although encouraging traditional healers to refer their mentally ill patients to the local clinics is a step in the right direction, it should be noted that there is a significant problem of non-detection in primary care settings. Many patients with a mental illness are either undiagnosed or misdiagnosed and, therefore, inadequately treated in such settings (Freeman, 1992).

Several limitations of this study must be considered when interpreting these findings. First, questions could be raised about whether participating in the study caused patients to change referral behaviour and, thus influence the results (i.e. a Hawthorne effect). Secondly, self-reports rather than objective measures of behaviour were obtained due to budget and time restraints. Thirdly, since a convenience sample of traditional healers from the Eastern Cape was utilized, the results cannot necessarily be generalized to the South African traditional healer population. Some of the traditional healer practices and beliefs may differ across provinces. Finally, the study was conducted in African languages, which the person collecting

the data (KS) does not speak. Finally, the researcher being perceived as an outsider could have also effected the results of this study.

Despite these limitations the results of this study emphasize the importance of educating traditional healers on the fundamentals of mental disorders, including mood and anxiety disorders. Designing interventions that are theory-based and effective may provide traditional healers with the information and skills they require to act as a valuable information and referral resource for mentally ill South Africans. For example, since attitude was a very strong predictor in this study, interventions illustrating the practice and effectiveness of Western psychiatric care for patients may be useful in changing traditional healer practices. Future research should focus on the design and implementation of training programs to increase the mental health literacy and referral practices of traditional healers and to assess the effectiveness of these programs.

CHAPTER 7

CONCLUSION

7.1 Introduction

The previous four chapters (chapters 3-6) attempted to answer the five research questions posed at the outset of this thesis. Although I provided an in-depth discussion of the major findings in these chapters, there was no opportunity to summarize all the findings and to explore relationships between the results reported in these four chapters. This conclusion aims to fill this gap by providing an opportunity to collate and discuss the findings presented in the previous chapters. This closing chapter will first attempt to answer the main research questions formulated in the introductory chapter. Thereafter, policy, practice and training implications are discussed, and finally areas for further research are delineated.

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7.2 Answering the Research Questions

In the introductory chapter, five research questions were formulated, which were then answered in some detail in 4 separate studies described in the following chapters. The answers to the research questions posed will now be discussed in brief.

#1. To what extent do patients suffering from a mental illness in South Africa consult traditional healers for their emotional and mental health care concerns?

This question was answered in Chapter Three of this thesis. To date, only a few studies have investigated the use of traditional healers for mental health care concerns in South Africa (Ensink & Robertson, 1999; Freeman et al., 1994). Results of these studies report that approximately one-half (41-61%) of patients have consulted a traditional healer for their mental health concerns (Ensink & Robertson, 1999; Freeman et al., 1994). However, these were small studies employing a range of convenient sampling methods, leading to results that

are difficult to generalise to the South African population as a whole. The data from this study is the first to describe the use of alternative medicine for mental health care in a nationally representative population sample in South Africa.

Of the 28% of participants who sought treatment (regardless of whether they met lifetime DSM-IV criteria for a disorder or not), 21% were treated by Western practitioners, 13% were treated by alternative practitioners, and 7% by a combination of both Western and alternative practitioners. Similar proportions were reported in participants with and without a common mental disorder. Of the subjects who sought treatment from alternative medicine, 6% sought treatment from a traditional healer, 7% from a spiritual or religious advisor, and 2% from another type of healer. However, while 14% of respondents sought treatment from a Western practitioner exclusively, only 2% sought treatment from a traditional healer exclusively. Results indicated that use of a traditional healer in the full sample were predicted by older age, black race, unemployment, lower education and having an anxiety or a substance use disorder.

#2. What are the explanatory models of non-psychotic mental disorders among traditional healers?

Chapter Four of this thesis answered this question. Although a few studies have been conducted in South Africa investigating traditional healers' perceptions of, and approaches to the treatment of mental illness, none of them have specifically examined non-psychotic disorders (Koen et al., 2003; Mufamadi, 2001; Mzimkulua & Simbayib, 2006; Robertson, 2006; Thorpe, 1992). Therefore, this study examined traditional healers' explanatory models and treatment practices for a number of mental illnesses. Focus group discussions and in-depth interviews were conducted with 50 traditional healers in Mpumalanga. One vignette for each of the following disorders was presented: schizophrenia, depression, panic and somatisation.

Results of the present study revealed that the symptoms presented by patients with a mental illness are predominantly behavioural and included undressing and urinating in public, violent and aggressive behaviour. Additionally, multiple causes of mental illness were described, including witchcraft, possession by evil spirits, substance abuse, life stressors and *thwasa* (calling to be a healer). Additionally, many of the healers in the present study did not believe that a patient with schizophrenia was suffering from a mental illness, but rather their

symptoms were simply a result of the patient being called by his ancestors to become a traditional healer *(thwasa),* "thinking too much" or suffering from stress caused by frustration and social problems. Although all of the healers claimed that they frequently treated mentally ill patients, many were hesitant to disclose their treatment practices.

The traditional healers in the study hold multiple explanatory models of non-psychotic disorders. A majority of the healers regard non-psychotic disorders as a reaction to difficult life situations and as a relatively normal reaction to severe social and personal threats and losses. Therefore, a non-psychotic disorder would not typically be identified as a mental illness unless it acquires other characteristics such as severe behavioural disturbance.

#3 What are the specific treatment practices for mental disorders used by South African traditional healers?

This question was answered in Chapter Four of this thesis. Although a few studies have been conducted in South Africa investigating traditional healers' perceptions of, and approaches to the treatment of mental illness, none of them have specifically examined non-psychotic disorders (Koen et al., 2003; Mzimkulua & Simbayib, 2006; Robertson, 2006; Mufamadi, 2001; Thorpe, 1992).

The results of the present study revealed that most traditional healers conceptualize non-psychotic disorders are as stress-related, or a result of "thinking too much". Many did not offer treatment for these problems, although practical support was often provided for these patients in need. The few healers that reported the patients in the non-psychotic vignettes were suffering from physical disorders (such as HIV/AIDS, hypertension and other physical problems) did claim they had the skills to treat these illnesses. For psychotic illnesses, such as schizophrenia, traditional healers reported using herbs and substances not solely from "traditional" sources but rather having incorporated "modern" ingredients that are potentially toxic into their treatment practices.

#4. Are interventions designed to educate traditional healers in Western methods effective?

This question was addressed in Chapter Five of this thesis. Traditional healers have been involved in a number of HIV and AIDS prevention programs (Green 1994, 1995; UNAIDS, 2000, 2002). To date, various intervention strategies have been adopted to educate traditional

healers in the fundamentals of STI and HIV medicine. However, no systematic review has thus far attempted to evaluate the effectiveness of interventions for educating traditional healers in the fundamentals of STI and HIV medicine. Therefore, a review using the methodology of the Cochrane Collaboration was conducted.

Two studies met the inclusion criteria; both of the studies assessed the effectiveness of interventions compared with control groups which received no education intervention. Two additional studies have been located, however their outcome measures were unavailable. Of the two included studies, both studies were rated as being of low quality. Although the studies included in this review reported a range of positive outcomes, the small number of studies, combined with heterogeneity of interventions and lack of explicit outcomes means it was not possible to draw generalized inferences about the effects of these interventions.

#5. What are the beliefs and attitudes associated with traditional healers and their decision to refer adolescents and adults suffering from a mental illness to a Western Practitioner?

This question was answered in Chapter Six of this thesis. Identifying factors associated with traditional healer referral of mental health patients is important for developing and designing interventions to ensure traditional healers refer more frequently and appropriately. If Western and traditional medicine are to work side by side, collaboration in the form of referral is essential. Behavioural theories can assist with identifying the determinants of a behaviour which is imperative when developing interventions, since interventions that address these determinants are more likely to be effective (Bartholomew, Parcel, Kok, & Gottlieb, 2000). Given the obvious significance of attitudinal factors when addressing the concept of referral, the Theory of Planned Behaviour (TPB) was the theoretical framework used to address this issue. The present study applied an extended version of the TPB, containing separate measures of knowledge and past behaviour to the prediction of traditional healer referral practices, specifically for mentally ill patients.

This study was conducted in two phases. Phase One utilized data collected from 3 focus groups where 24 traditional healers were used to elicit the indirect measures of the TPB. These included common beliefs about referring, advantages and barriers to referring, and groups or institutions that would influence their decision to refer their patients. The findings of this phase resulted in the construction of questionnaire items relating to behavioural beliefs, normative beliefs, and control beliefs about referral practices utilized in part 2 of this study.

Similar to the findings reported in Chapter Four, the traditional healers in the present study identified a mentally ill patient through extremely abnormal behaviour and episodes of violence. The traditional healers report that the main advantages of Western psychiatric medicine are not always specific to psychiatry, and view the treatments provided not as a cure, but as a temporary measure. It appears that Western medicine is essentially viewed as a viable option under extreme circumstances when patients show signs of excessive violence or dehydration. The traditional healers believed Western doctors were capable of curing patients who suffer from a mental illness NOT caused by bewitchment (for example, those born with illness, or suffering from an illness caused by alcohol or other substance use). Additionally, many of the healers reported that Western doctors do not respect them or their practices, and often get blamed if a patient dies.

In Phase Two, 100 traditional healers were interviewed to assess the TPB variables (attitudes, subjective norms, perceived behavioural control) relevant to intentions to refer mentally ill patients, with the addition of a measure of past referral behaviour and knowledge of mental illness. In order to measure self-reported behaviour, all traditional healers were contacted 5 months following the initial interview. The findings of the present study show the potential for the TPB to be a useful model in predicting the referral practices of traditional healers. The TPB constructs of attitudes and perceived behavioural control significantly predicted traditional healer referral practices. However, subjective norms were not a significant predictor of traditional healer referral practices. Additionally, past behaviour predicted traditional healer referral practices, while knowledge of mental illness did not. Stronger intentions to refer patients predicted greater self-reported behaviour. Finally, herbalists were less likely than diviners and faith healers to refer their mentally ill patients to a Western healthcare professional should they not respond to treatment.

7.3 Potential Implications of Study Results

In this section, some conclusions and implications will be formulated on the relations between policy, practice and training.

7.3.1 Implications for Policy

As previously mentioned in Chapter Two, over the past several decades, support for traditional medicine has dramatically increased worldwide. Some countries such as the

Democratic People's Republic of Korea, Vietnam, and China have already taken action to officially recognize traditional medicine by fully integrating their mainstream medical care systems with traditional medicinal practices. Yet these countries are in the minority in terms of fully legitimizing the practice of traditional medicine, while another 70 countries worldwide have only begun to introduce legislation for herbal medicines and plants (WHO, 2002).

Due to the devastating impact of the AIDS epidemic, the WHO recommends that traditional healers be officially recognized in those countries where they can assist with diagnosis and referral. In line with these recommendations, the degree of recognition of African Traditional Medicine by the South African government continues to increase. Two formal legal structures were put in place to recognize African Traditional Medicine in South Africa: The Traditional Health Practitioners Bill establishing the Traditional Practitioners Council, and the draft National Policy on African Traditional Medicine in South Africa.

Although the outcome of the draft National Policy is yet to be determined, governmental processes have delayed the implementation of the Traditional Health Practitioner's Bill, up to the current day. One of the major critiques of the present legislation is that it failed to include concrete avenues through which this legislation could be implemented (Pefile, 2005). The process of attaining unity between traditional healers will be lengthy and complicated (Devenish, 2005), and it is possible that the time frames laid out in the Bill were unrealistic.

Additionally, the WHO's recommendations focus on the use of traditional healers to combat the devastating impact of HIV/AIDS, and does not extend to advocating integration into the primary health care system. Nor is there any mention of their potential in providing mental health care to communities. Results of the present thesis indicate that further debate around the most appropriate way to collaborate with traditional healers for mental health care issues is required. The major reasons for further debate include a lack of awareness of how low the extent of traditional healer use is, and the lack of evidence available on their efficacy and effectiveness in treating the mentally ill. There is a great need for dialogue between traditional and Western practitioners in regard to mental health care prior to future collaborative efforts being initiated.

Low Use of Traditional Healers

There is a common assertion that 60%-80% of Black South Africans consult traditional healers for their healthcare needs, and this is one of the main arguments for officially recognizing traditional healers as health care professionals. However, reliable data on the extent of traditional healer use is scarce. I am not the only one who struggled locating the original source for this rather high statistic. Adam Ashforth (2005) described his search for the source whereby every time the ubiquitous locution "it has been estimated that…." was cited, the reference turned out to be another author, claiming without accurate attribution that "research has shown that…." However, the results of the present nationally representative study (Chapter 3), reveal that extent of traditional healer use may be much lower. Although a nationally representative study estimating traditional healer use in other health conditions is not available, the results of this present study may be indicative of the trend.

The findings described in Chapter Three revealed that South Africans consult Western health practioners more frequently than traditional healers for their mental health concerns. However, this study included South Africans suffering only from non-psychotic disorders, and did not include those with psychotic disorders. Since the findings reported in Chapter Four revealed that traditional healers do not view non-psychotic disorders as a mental illness, it may be that they are consulted more frequently by South Africans suffering from psychotic mental disorders. Despite this potential limitation, these relatively low percentages are consistent with a studies conducted in Nigeria and Ghana, were 26% and 6% of patients suffering from a mental illness consulted a traditional healer prior to presenting themselves to a mental health professional (Abiodun, 1995; Appiah- Poku et al., 2004).

The data also suggested that a number of variables predicted traditional healer use, including lower education, older age, black race, employment, and having an anxiety or a substance use disorder. Individuals with little or no formal education were more likely to consult traditional healers than those South Africans who were more educated. This may be because respondents with more education are educated in the Western biomedical model and are therefore more likely to pursue Western biomedical help. Additionally, the finding that older participants were more likely to seek care from traditional healers, is consistent with previous research suggesting that younger participants in Ethiopia were more likely to seek health care from modern health services (Berhane et al., 2001). The younger generation appears to be turning to other sources of health care to fulfil their health care needs. Therefore, it is possible that traditional healers may be used less and less often in the future.

Particularly striking is the comparatively low proportion that used traditional healers compared to the higher proportion that used religious and spiritual advisors in the black population. Forty nine percent of the black respondents reported consulting with a religious or spiritual advisor and only 21% consulted with traditional healers. Thus religious and spiritual advisors may be consulted more frequently than traditional healers for mental health care concerns. These results are similar to those found in a study conducted in Ghana that reported 14% of patients had consulted with a pastor, compared to 6% consulting traditional healers before presentation to mental health services (Appiah-Poku, 2004).

Little research has been conducted on attitudes of church pastors in urban or rural Africa, although the growth of their involvement has been noted (Pfeiffer, 2006). Although anecdotal, it is believed that the advent of the faith healer can be seen as an outgrowth of the influence of urbanization, acculturation, Christianity, and the African independent church movement. It has been argued that the high cost of traditional medicine has paved the way for the African Independent Churches and the Pentecostal movements to offer their congregants "cost free" alternative to healing (notwithstanding the sometimes exorbitant financial obligations of church membership) (Edwards et al., 2003). Evidence for this change, is provided by a study conducted in Zimbabwe in 2002-2003 as part of a larger study of African Independent Church (AIC) and Pentecostal expansion. Members and recent converts of ten churches were interviewed in addition to in depth interviews with 80 pastors, prophet healers, traditional healers and other community leaders. In these interviews the common theme of payment and how it influenced the authenticity of the traditional healers' practices emerged frequently (Pfeiffer, 2006).

If it is the case that religious advisors are playing a substantial role in the delivery of health care in South Africa, there is potential for substantial policy implications. Traditional healers practicing in Africa can be described as priests of the religious system of African Traditional Religion. According to Robertson (2006), traditional healers in the spiritual and existential sphere and resemble faith-based practitioners' more than medical practitioners. However, with the passing of the Traditional Health Practitioners Bill, they are presently being encouraged to register with the Health Professionals' Council in an attempt to regulate their practices (Sidley, 2004). Registering with the health professionals' council is a move to grant these traditional healers the status of health professionals. However, other religious advisors in South Africa are not being regulated in the same manner (www.doctorsforlifeinternational.com), despite the fact that they also prescribe treatment to

those who are ill. Effectiveness not withstanding, it may be beneficial for the governments to include religious and spiritual advisors when looking for ways to meet the healthcare requirements of the community. However, granting them the status of a health care professional may not be the most appropriate way forwards. Further debate around the issue of whether traditional healers and religious advisors should be given the status of health care professionals is required.

Efficacy of Traditional Medicine

Secondly, all South Africans have the right to safe and effective treatment and medicine, regardless of whether the medicine is classified as Western or traditional. Although the Traditional Health Practitioners Bill does state that diagnosing, treating or offering to treat cancer, HIV/ AIDS or other terminal diseases is recognised as an offence, traditional healers are free to treat and manage mentally ill patients in their community. This is despite the lack of evidence available of their efficacy in treating the mentally ill. At the present time, there is little—if any—research available confirming the effectiveness of traditional herbal medicine in treating mental illness (or any illness for that matter). As the present study reveals (Chapter 4), it appears traditional healers do not solely utilize traditional herbs as ingredients for their treatment; rather they have incorporated "modern" ingredients into their practices. However, the safety of ingesting "modern" ingredients (such as methylated spirits) warrants concern. Prior to being made available to the public, all medicines should fulfil the same uniform standards, tests and trials (Richter, 2003).

Yet, to be fair, similar to traditional medicine, Western medicine is not devoid of potential harm. Western medicine has its side effects, difficulties and failures (Hillebrund, 2006). Similarly, like traditional medicine, each individual practitioner is responsible for their own practices, whether they by scientific or founded on the basis of good values. The key distinction between these two systems of health care appears to be that Western medicine has particular legal, ethical mechanisms (guidelines, codes and regulations), and a commitment to the scientific method, which serve the important purpose of role of reducing any potential harm to patients. These standards make it illegal for Western practitioners to prescribe medicines to patients that are not registered with the relevant national drug regulatory authorities. It appears these regulations do not apply to the treatments prescribed by traditional healers (van Boggaert, 2007). Although not all traditional or Western healthcare

professionals follow a scientific approach, there is a need for all practices to be considered through a scientific lens. Therefore, while efforts by the South African government may be viewed as a step in regulating traditional medicine, whether or not these steps are sufficient enough to protect the South African public from harm, or encourage health, is unclear. Resources should be channelled towards research into the efficacy and safety of traditional medicines.

Need for Dialogue

There is a need for dialogue between traditional and Western practitioners in regard to mental health care. The mutual lack of trust, respect and understanding between Western and traditional medicine is situated within the context of the ongoing debate within the South African mental health literature as to whether, or in what form, traditional healers should collaborate with health practitioners in the formal mental healthcare sector (Abdool Karin & Ziqubu-Page, 2004; Robertson, 2006). The literature often reports distrust and scepticism from Western doctors towards traditional healers, but the results of the present study reveal that these feelings may not only be one-sided (Chapter 6). In order to foster an understanding of each other's potential contribution in treating the patient physically and spiritually, it may be helpful for traditional healers and modern health care practitioners to meet in forums where they can exchange knowledge and discuss what each group hopes to gain from collaborating. These factors assume particular significance given the recent promulgation of the Traditional Health Practitioners' Bill.

The implications for the practices of traditional healers will now be discussed.

7.3.2 Implications for Practice

Psychotic disorders

Traditional healers in the present study identified a mentally ill patient through extremely abnormal behaviours and episodes of violence (Chapter 4 & 6). As detailed above, this finding is consistent with previous studies in this area (Aidoo & Harpham, 2001; Patel et al., 1999). For example, wandering away from home, eating or smearing faeces and laughing at

inappropriate times were reported to be common behaviours of a mentally ill patient. In addition, impaired self-care such as not washing or eating dirty food was noted.

Almost all the healers interviewed claimed they had the capabilities of "curing" a mentally ill patient (Chapters 4 & 6). Yet, at the present time, treatments prescribed by a traditional healer for mental health concerns have not been shown to be effective. Although the results of the present study are difficult to generalize to the South African population, the safety of ingesting ingredients such as methylated spirits and benzene does warrants concern.

Although Western medicine does not claim to have a "cure" for mental illness, drug treatment is effective in managing acute psychosis and in reducing the risk of relapse (Volz, Khorsand, Gillies, & Leucht, 2008). Clinical trials have demonstrated the efficacy and cost-effectiveness of locally feasible treatment for a number of mental illnesses, including severe psychiatric disorders (Chatterjee, Patel, Chatterjee, & Weiss, 2003). This has particular significance given that severe mental disorders, such as schizophrenia, are potentially life threatening, and may affect many aspects of a person's life and general health. They are also reported as being closely linked to suicide (McGirr & Turecki, 2007). According to Meltzer (1998), the rate of suicide attempts in patients suffering from schizophrenia lies between 20 and 40%.

Despite the evidence to suggest that early identification and treatment has the potential to improve the outcome for people with schizophrenia (Ho & Anderson, 2001), the findings of the present indicate that consulting a traditional healer may be a barrier to receiving appropriate mental healthcare (Chapter 6). It was not regular practice for all traditional healers in the present study to refer their mentally ill patients to the local clinic should their patient not respond to treatment (Chapter 6). The traditional healers did not feel that Western medicine had much to offer a mentally ill patient. Western medicine is essentially viewed as a viable option under extreme circumstances when patients show signs of excessive violence or dehydration.

This practice of referring violent and dehydrated mentally ill patients could potentially be an opening for possible collaboration between traditional healers and the local clinics in the treatment patients suffering from a mental illness. Although formally engaging traditional healers in treating mentally ill patients may prevent appropriate diagnosis and treatment for the mentally ill, a pragmatic approach would be to work within the current structures for positive change. Traditional healers in the present study also reported taking mentally ill

patients into their own households (Chapter 4). If these patients sought treatment from a Western medical professional, traditional healers could potentially play a pivotal role in ensuring their adherence to treatment and providing a setting where they can integrate back into the community.

Non-psychotic disorders

The traditional healers in the present study held multiple explanatory models of non-psychotic disorders (Chapter 4). A majority of the healers regard non-psychotic disorders as a reaction to difficult life situations and as a relatively normal reaction to severe social and personal threats and losses. Therefore, a non-psychotic disorder would not be identified as a mental illness unless it acquires other characteristics such as severe behavioural disturbance. These findings are relatively similar to previous studies conducted in Africa (Aidooi & Harpham, 2001; Okello, 2006; Patel et al, 1995a, 1995b) and coincide with Patel's conclusion that many Africans do not consider non-psychotic disorders to be a mental illness (Patel, 1996, 1997).

Since many of the healers did not consider a non-psychotic disorder to be a mental illness, not only were these patients not prescribed herbal treatment (Chapter 4), but were also never referred to a Western healthcare professional (Chapter 6). A number of healers described more practical ways they could help these patients, such as giving them money or helping them find a job. In addition, many of the healers mentioned counselling, which could be provided by either a Western or traditional health care professional, as an option to help these patients. Since some less severe mental illnesses recover spontaneously, dealing with mentally ill patients in this manner may be less harmful to patients then some of the treatment options provided by traditional healers.

On the other hand, many mental illnesses, such as depression, can potentially be life threatening, if they are not treated appropriately. The lifetime risk of suicide in those affected by major depression and bipolar has been estimated at 6–15% (Inskip, Harris, & Barraclough, 1998). There is data available on the efficacy of Western medical interventions in people suffering from non-psychotic disorders in the developing world (Bolton et al., 2004; Patel et al., 2001; Stein & Gureje, 1993). For example, Patel et al. (2001) found that the antidepressant fluoxetine was superior over the short term to both placebo and counselling for depression in primary care in India. Therefore, since at the present time there is no evidence to suggest that traditional healers are effective in treating

patients suffering from a non-psychotic mental illness; they can again be considered a potential barrier to receiving effective treatment.

The next section will look at the implications the present study has on the training of traditional healers.

7.3.4 Implications for Training

The results of the present study (Chapter 3, 4 & 6) have implications for addressing the issue of limited psychiatric care in South Africa. Given the relatively low number of Western psychiatric practitioners, there may be value in working with traditional healers and spiritual advisors in this regard. Acknowledging the possible role of churches in providing care together with educating and working with church pastors may be an important way forward in improving mental health care if their practices have been shown to effective and safe (Chapter 3). Traditional healers and religious and spiritual advisors are widely dispersed throughout South Africa, are knowledgeable of culture norms, and their advice is sought, believed and acted upon by community members, since they share similar explanatory models of mental illness (Chapter 4). Organized and well trained traditional healers and religious and spiritual advisors have the potential to play a significant role in mental health treatment and as a referral resource in the South African context (Chapters 4, 5 & 6).

As described in Chapter Five, a number of workshops have been conducted aimed at lessening the harmful effects of some traditional healer practices and encouraging health promotion, mostly in the area of HIV and AIDS (Green et al., 1995; King & Homsey, 1997; Peltzer et al., 2006; Rudolph et al., 2007). However, the systematic review described in Chapter Five which assessed interventions for educating traditional healers about STD and HIV medicine resulted in inconclusive findings. Although the two studies included in this review reported a range of positive outcomes, the small number of studies, combined with the heterogeneity of interventions, means it is not possible to draw generalizable inferences about the effects of these interventions. Despite marking a step forward in beginning to establish an evidence base for traditional healer interventions, more rigorous research is required to demonstrate evidence of the impact of this type of intervention on professional practice or healthcare outcomes or both.

The results of the present study indicate that although further research is required, well designed interventions to increase the mental health literacy of traditional healers may be

beneficial (Chapter Five). Despite the finding that non-psychotic mental illnesses, such as depression, that can be potentially life threatening, traditional healers do not consider them to be a mental illness (Chapters 4 & 6). Additionally, many of the healers in the present study did not believe that a patient with schizophrenia was suffering from a mental illness, but rather their symptoms were a result of the patient being called by his ancestors to become a traditional healer *(thwasa),* "thinking too much" or suffering from stress caused by frustration and social problems. The training and provision of accurate information are necessary to address the current gaps in knowledge of traditional healers regarding mental illness. Equipping traditional healers to understand and effectively manage mental illness in their communities will contribute towards traditional healer's optimal utilization. Only one intervention to date has been conducted with traditional healers on mental health matters (Adelekan, 2001). However, similar to the studies assessing HIV interventions (Chapter 5), although a range of positive outcomes were reported, the sample size was small, not randomized and of relatively low quality.

Although the results of the present study (Chapter 5) reveal that future interventions aimed at traditional healers should use more rigorous methodology, designing interventions that are theory based can also assist (Bartholomew et al., 2001). The TPB has been widely used to explore factors associated with health professionals' beliefs and attitudes to health-related behaviour (Limbert & Lamb, 2002; McCarty et al., 2001;Walker, Grimshaw & Armstrong 2001), although only a few have utilized the TPB to address referral practices of health care professionals (Conner & Heywood-Everett, 1998; Millstein, 1996). Designing interventions that are theory-based may provide traditional healers with the information and skills they require to act as a valuable information and referral resource for mentally ill South Africans. The results of the present study (Chapter 6) demonstrate the potential for the TPB to be a useful model in predicting the referral practices of traditional healers.

In the present study a number of factors were associated with traditional healer referral practices. These constructs should be included in the development and design of interventions to ensure traditional healers refer more frequently and appropriately. For example, since attitude was a very strong predictor in this study, interventions illustrating the practice and effectiveness of Western psychiatric care for patients may be useful in changing traditional healer practices. The study showed that the TPB can contribute to the understanding of behaviours such as traditional healer referral and may be useful in understanding how behaviour change occurs and in designing interventions to promote behaviour change.

However, although increasing the mental health literacy of traditional healers, and encouraging them to refer their mentally ill patients to the local clinics is a step in the right direction, there is a significant problem of non-detection in primary care settings. Many with psychiatric disorders are either undiagnosed or misdiagnosed and, therefore, inadequately treated (Freeman, 1992). Interventions designed to increase the mental health literacy and decrease the stigma associated with mental illness targeted at primary health care workers is also essential. These workers may be in a good position to share their knowledge with the traditional healers. It is these community workers that should be collaborating with the traditional healers at ground level to encourage appropriate referral practices.

Finally, a number of studies have provided evidence that some traditional healer treatment practices cause considerable harm to patients (e.g. Chipfakacha, 1997), but the findings of these studies do not get disseminated to those who need it most, the traditional healers. Scientific articles are inaccessible and incomprehensible for traditional healers. Often the information found in the research is extremely important– a question of life and death – that needs to get out to healers. Dissemination of this information could be provided in the form of training sessions or workshops.

On a similar note, since many traditional healers in South Africa advertise themselves as having a "cure" for mental illness and consultation with healers can be relatively pricey, it is important to educate the South African population about the positive and negative consequences of alternative practices to ensure they are making fully informed decisions when choosing the appropriate health practitioners. Furthermore, due to the potential harm of traditional healer treatment of severe mentally ill patients, Western health care practitioners should be advised to ask patients if they had consulted a traditional healer before and what recommendations were made, and to discuss the implications of simultaneous traditional and Western healing interventions.

Finally, in order for successful collaboration to occur Western mental health care professionals should undergo introducing training on spiritual/traditional models of illness and the role traditional healers' play in treating mentally ill South Africans. This training could be integrated into at least courses of psychiatry, in not broader coursework in medical education. These courses could involve medical and psychological anthropologists working in

conjunction with open-minded traditional healers in developing and teaching these courses. At a minimum, this has the potential to address some of the distrust that persists between traditional healers and biomedical Western healthcare professionals.

7.4 Future Research

Although the results of the present study provide some answers on the role of traditional healers in mental health care in South Africa, there still remains a lack of awareness, research and information on traditional medicine, specifically regarding mental illness.

The data described in Chapter Three was the first to describe the use of traditional healers for mental health care in a nationally representative population; however, it did not include South Africans who live in institutional settings including mental hospitals. Therefore, these findings may not hold for severely mentally ill patients, which appear to be the main exemplar of mental illness according to the traditional healers described in Chapter Four. We also did not have data on which service provider the subject saw first. More information on this would be helpful in understanding pathways to treatment. It would be beneficial if future research addressed some of these limitations. Additionally, the finding that religious advisors are consulted for mental health concerns warrants particular attention. Little research has been conducted on religious advisors in South Africa and their treatment practices. Future research should focus specifically on religious advisors and their treatment practices for the mentally ill.

While Chapter Four provided valuable insight into traditional healers' explanatory models and treatment practices for mental illness, this was a qualitative study that utilized a convenience sample of traditional healers from Mpumalanga. Also, when investigating the actual treatment practices of traditional healers for mentally ill patients, many did not wish to disclose their practices. Therefore, the results of this study cannot be generalized to the South African traditional healer population as a whole. Future research should focus on replicating this study using larger samples that represent traditional healers from various regions across South Africa. The findings of this study also highlight the need for the identification and examination of the pharmacological effects of the medicinal plants (and modern substances) used to treat mentally ill patients (as defined by traditional healers). This would allow

researchers to assess traditional healer's ability to treat mental illness and to reduce any harmful side effects that may result from some treatments.

Chapter Five aimed to determine whether interventions to educate traditional healers in HIV and STI medicine result in an increase in knowledge, however, the results were inconclusive due to methodological heterogeneity amongst the studies. Future randomised controlled studies explicitly focused on interventions with rigorous randomisation procedures and allocation concealment, larger sample sizes, and more appropriate control groups, would improve the evidence base for interventions aimed at traditional healer in HIV/AIDS medicine. Furthermore, a more studies assessing interventions for educating traditional healers not just about HIV/AIDS, but about all Western health care practices, would be beneficial, including mental health.

Chapter Six applied the TPB to predict traditional healer referral practices. The participants in Phase One were selected using convenience sampling from SADAG workshops, and are therefore representative of that particular population only. Phase Two utilized the snowballing method to obtain participants which has similar limitations. Phase 2 also utilized self-reports rather than objective measures of behaviour due to budget and time restraints. Replicating these studies using larger samples that represent traditional healers from various regions across South Africa, with more appropriate measures of behaviour is required. Future research should also focus on the design and implementation of training programs to increase traditional healers referral practices of mentally ill patients should their treatment not prove effective. It is also important that the effectiveness of these programs be assessed appropriately. Therefore, while the results of thesis provide a better understanding of traditional healers and their beliefs, practices and contribution to mental health care in South Africa, further research and more dialogue between traditional and mental health care professionals is essential in order to determine the most effective way to collaborate.

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Appendix 1

Interview Schedule for Assessing Traditional Healers Explanatory Models

THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

P O Box 652548 Benmore 2010
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Consent Form

Katherine Sorsdahl, a researcher at the University of Cape Town working with the South African Depression & Anxiety Group (SADAG) wants to get a better understanding about what you know about stress and mental illness, including how you would treat these problems. We will be using this information to create workshops that will help Traditional Healers and Western Practitioners to work together more effectively in the future.

We would like you to talk with us about your attitudes and beliefs about Mental Illness and the experiences you have with your patients.

If you decide to participate in this interview:

1) We would like you to answer the questions as honestly as possible.
2) Your answers are completely private. Only the main researcher will see the answers you provide, and you will not be identified at any stage of the research. Your name and personal details will not be used. Your completed questionnaire will be stored in a locked room at the SADAG offices in Johannesburg.
3) You can choose not to answer any questions that you do not like
4) If you choose not to participate, there will be no bad feelings towards you. You will continue to receive all the support SADAG can give you.

I understand what this form is and agree to participate in the interview

Full Name: _____

Telephone Number: _____

Signature: _____

1. Are you a man or a woman? ☐ Man ☐ Woman

2. How old are you?_____

3. What kind of healer are you?

☐ Sangoma
☐ Inyanga
☐ Faith Healer
☐ Other

4.How much school did you finish?
☐ Did not finish primary school
☐ Finished primary school
☐ Finished high school (secondary school)
☐ Finished tertiary education

5. How long have you been a traditional healer for?
☐ under 1 year
☐ 2 years to 3 years
☐ 4 years to 6 years
☐ 7 years or more

6. How long was your training?
☐ Less than 1 year
☐ 1-2 years
☐ 2-4 years
☐ more than 4 years

7. How many patients do you see a week?
☐ 1- 5 patients
☐ 6-12 patients
☐ 13-24 patients
☐ 25 or more

8. Do you know mentally ill patients in our community?

Yes ☐ No ☐

9. If yes, please describe this patient to me? (probe: How do they act.. what do they do etc..)

_____
_____
_____

I would like to ask your thoughts about some people who visited a traditional healer. I am going to read you a short story and then ask you a few questions about it.

A. Tshepo is 44 years old. She has not worked for years. She wears the same clothes all the time and has left her hair to grow long and untidy. She is always on her own and is often seen sitting alone and talking to herself. She is hearing voices, and believes that the government

and the police are out to get her. She thinks that people are spying on her and that they know what she is thinking. Although she is polite, she does not like talking to other people. She has asked her landlord to put extra locks on her door and to remove the television set from her room. She says spies are trying to keep an eye on her because she has secret information

What if anything is Tshepo's problem?

_____
_____
_____

Does Tshepo have an illness? If yes, what is it?

_____
_____
_____

What do you think caused Tshepo's problem?

_____
_____
_____

What should Tshepo do about it?

_____
_____
_____

What should a Traditional Healer do about it?

_____
_____
_____

Would you treat this problem? If yes, what would you do? ? (Probe: if struggling bring up similar patient in past and elicit treatment plan).

_____
_____
_____

B. Brian, a 34 year old taxi driver goes to see a traditional healer. He can not get on a bus since a friend of his was attacked at work. He has been off work for four months now. Because of this his family has money problems and they are very late paying their rent. He used to go shopping with his wife, but now does not like going into supermarkets. When he is around lots of people he starts sweating and feels stressed and panicky. When this happens he feels that something bad is going to happen to him. He now spends much more time inside.

What if anything is Brian's problem?

_____
_____
_____

Does Brian have an illness? If yes, what is it?

_____
_____
_____

What do you think caused Brian's problem?

_____
_____
_____

What should Brian do about it?

_____
_____
_____

What should a Traditional Healer do about it?

_____
_____
_____

Would you treat this problem? If yes, what would you do? (Probe: if struggling bring up similar patient in past and elicit treatment plan).

_____
_____
_____

C Sarah, a 45 year old machine operator married with two children has been feeling tired, a little angry and does not have much energy. She has trouble getting to sleep and she gets stomach pains and her back and legs ache most of the time. Because of this she has problems caring for her children and does not enjoy being around them like she use to. She has been to many traditional healers (and doctors). But no one can find anything wrong with her. She now wants to sit around the house watching the television..

What if anything is Sarah's problem?

_____
_____
_____

Does Sarah have an illness? If yes, what is it?

_____
_____
_____

What do you think caused Sarah's problem?

_____
_____
_____

What should Sarah do about it?

_____
_____
_____

What should a Traditional Healer do about it?

_____
_____
_____

Would you treat this problem? If yes, what would you do? ? (Probe: if struggling bring up similar patient in past and elicit treatment plan).

_____
_____
_____

D. Jennifer is a 29 year old single mother with two small children. They live in a small, old house that is paid for by benefits. She feels low in energy, has lost weight, does not sleep well and feels the worst in the mornings. She feels her life is not worth living and worries about what will happen to her in the future. At times, if it was not for her children she think she may end her own life. Her boyfriend pops in from time to time but is not prepared to contribute to childcare..

What if anything is Jennifer's problem?

_____
_____
_____

Does Jennifer have an illness? If yes, what is it?

_____
_____
_____

What do you think caused Jennifer's problem?

_____
_____
_____

What should Jennifer do about it?

_____
_____
_____

What should a Traditional Healer do about it?

_____
_____
_____

Would you treat this problem? If yes, what would you do? (Probe: if struggling bring up similar patient in past and elicit treatment plan).

_____

_____

_____

Appendix 2

Search Strategy for Assessing Interventions for Educating Traditional Healers about STD & HIV Medicine

1. Search Strategy for Pubmed

Number	Search Terms
#1	HIVInfections[MeSH]ORHIV[MeSH]ORhiv[tw]ORhiv-1*[tw]ORhiv-2*[tw]ORhiv1[tw]ORhiv2[tw]OR hiv infect*[tw] OR human immunodeficiency virus[tw] OR human immunedeficiency virus[tw] OR human immuno-deficiency virus[tw] OR human immune-deficiency virus[tw] OR ((human immun*) AND (deficiency virus[tw])) OR acquired immunodeficiency syndrome[tw] OR acquired immunedeficiency syndrome[tw] OR acquired immuno-deficiency syndrome[tw] OR acquired immune-deficiency syndrome[tw] OR ((acquired immun*) AND (deficiency syndrome[tw]))
#2	sexually transmitted diseseases, viral[mh:exp] OR sexually transmitted diseases, bacterial [mh:exp] OR (sexually transmitted disease) OR (sexually transmitted diseases) OR (sexually transmitted infection) OR (sexually transmitted infections) OR (genital ulcer) OR (genital ulcer disease) OR (genital ulcer diseases) OR (genital ulcers) OR (veneral disease) OR (veneral diseases) OR (venereal infections) OR (venereal infection)
#3	#1 OR #2
#4	randomized controlled trial [pt] OR controlled clinical trial [pt] OR randomized controlled trials [mh] OR random allocation [mh] OR double-blind method [mh] OR single-blind method [mh] OR clinical trial [pt] OR clinical trials [mh] OR ("clinical trial" [tw]) OR ((singl* [tw] OR doubl* [tw] OR trebl* [tw] OR tripl* [tw]) AND (mask* [tw] OR blind* [tw])) OR (placebos [mh] OR placebo* [tw] OR random* [tw] OR research design [mh:noexp] OR (comparative study) OR (comparative studies) OR (evaluation studies) OR (evaluation study) OR follow-up studies [mh] OR prospective studies [mh] OR control* [tw] OR prospectiv* [tw] OR volunteer* [tw]) NOT (animals [mh] NOT human [mh])
#5	medicine, traditional [mh:exp] OR Native Healer OR Native Healers OR Aboriginal healer or Aboriginal Healers or Indigenous Healer or Indigenous Healers or traditional healer OR traditional Healers
#6	Search #3 AND #4 AND #5 Limits: Publication Date from 1980 to 2008/04/04

2 . Search Strategy for Embase

Number	Search Terms
#1	('humanimmunodeficiencyvirusinfection'/expOR'humanimmunodeficiencyvirusinfection')OR('human immunodeficiency virus infection'/exp OR 'human immunodeficiency virus infection')) OR (('human immunodeficiency virus infection'/exp OR 'human immunodeficiency virus infection') OR ('human immunodeficiency virus infection'/exp OR 'human immunodeficiency virus infection'))) OR ((((('human immunodeficiency virus'/exp OR 'human immunodeficiency virus') OR ('human immunodeficiency virus'/exp OR 'human immunodeficiency virus')) OR (('human immunodeficiency virus'/exp OR 'human immunodeficiency virus') OR ('human immunodeficiency virus'/exp OR 'human immunodeficiency virus')))) OR ((((('b cell lymphoma'/exp OR 'b cell lymphoma') OR ('b cell lymphoma'/exp OR 'b cell lymphoma')) OR (('b cell lymphoma'/exp OR 'b cell lymphoma') OR ('b cell lymphoma'/exp OR 'b cell lymphoma')))) OR (hiv:ti OR hiv:ab) OR ('hiv-1':ti OR 'hiv-1':ab) OR ('hiv-2':ti OR 'hiv-2':ab) OR ('human immunodeficiency virus':ti OR 'human immunodeficiency virus':ab) OR ('human immunedeficiency virus':ti OR 'human immunedeficiency virus':ab) OR ('human immune-deficiency virus':ti OR 'human immune-deficiency virus':ab) OR ('human immuno-deficiency virus':ti OR 'human immuno-deficiency virus':ab) OR ('acquired immunodeficiency syndrome':ti OR 'acquired immunodeficiency syndrome':ab) OR ('acquired immuno-deficiency syndrome':ti OR 'acquired immuno-deficiency syndrome':ab) OR ('acquired immune-deficiency syndrome':ti OR 'acquired immune-deficiency syndrome':ab) OR ('acquired immunedeficiency syndrome':ti OR 'acquired immunedeficiency syndrome':ab) AND [1980-2008]/py
#2	'viral sexually transmitted diseases' OR 'bacterial sexually transmitted diseases'OR (('sexually transmitted disease'/exp OR 'sexually transmitted disease') OR ('sexually transmitted disease'/exp OR 'sexually transmitted disease')) OR (('sexually transmitted diseases'/exp OR 'sexually transmitted diseases') OR ('sexually transmitted diseases'/exp OR 'sexually transmitted diseases')) OR 'sexually transmitted infection'OR 'sexually transmitted infections'OR (('genital ulcer'/exp OR 'genital ulcer') OR ('genital ulcer'/exp OR 'genital ulcer')) OR 'genital ulcer disease' OR 'genital ulcer diseases' OR 'genital ulcers' OR (('venereal disease'/exp OR 'venereal disease') OR ('venereal disease'/exp OR 'venereal disease')) OR 'venereal diseases' OR 'venereal infections' OR (('venereal infection'/exp OR 'venereal infection') OR ('venereal infection'/exp OR 'venereal infection')) AND [1980-2008]/py
#3	#1 OR #2
#4	((random*:ti OR random*:ab) OR (factorial*:ti OR factorial*:ab) OR (cross?over*:ti OR cross?over*:ab OR crossover*:ti OR crossover*:ab) OR (placebo*:ti OR placebo*:ab) OR ((doubl*:ti AND blind*:ti) OR (doubl*:ab AND blind*:ab)) OR ((singl*:ti AND blind*:ti) OR (singl*:ab AND blind*:ab)) OR (assign*:ti OR assign*:ab) OR (allocat*:ti OR allocat*:ab) OR (volunteer*:ti OR volunteer*:ab) OR ((((('crossover procedure'/exp OR 'crossover procedure') OR ('crossover procedure'/exp OR 'crossover procedure')) OR (('crossover procedure'/exp OR 'crossover procedure') OR ('crossover procedure'/exp OR 'crossover procedure')))) OR ((((('double-blind procedure'/exp OR 'double-blind procedure') OR ('double-blind procedure'/exp OR 'double-blind procedure')) OR (('double-blind procedure'/exp OR 'double-blind procedure') OR ('double-blind procedure'/exp OR 'double-blind procedure')))) OR ((((('single-blind procedure'/exp OR 'single-blind procedure') OR ('single-blind procedure'/exp OR 'single-blind procedure')) OR (('single-blind procedure'/exp OR 'single-blind procedure') OR ('single-blind procedure'/exp OR 'single-blind procedure')))) OR ((((('randomized controlled trial'/exp OR 'randomized controlled trial') OR ('randomized controlled trial'/exp OR 'randomized controlled trial')) OR (('randomized controlled trial'/exp OR 'randomized controlled trial') OR ('randomized controlled trial'/exp OR 'randomized controlled trial'))))) AND [1980-2008]/py

#5	('traditional medicine'/exp OR 'traditional medicine') OR 'native healer' OR 'native healers' OR 'aboriginal healer' OR 'aboriginal healers' OR 'indigenous healer' OR 'indigenous healers' OR ('traditional healer'/exp OR 'traditional healer') OR 'traditional healers' OR 'aboriginal medicine' OR 'indigenous medicine' AND [1980-2008]/py
#6	#3 AND #4 and #5

3. Search Strategy for Gateway

Number	Search Terms
#1	(HIVInfections[MeSH]ORHIV[MeSH]ORhiv[tw]ORhiv-1*[tw]ORhiv-2*[tw]ORhiv1[tw]ORhiv2[tw]ORhivnfect*[tw] OR human immunodeficiency virus[tw] OR human immunedeficiency virus[tw] OR human immuno-deficiency virus[tw] OR human immune-deficiency virus[tw] OR ((human immun*) AND (deficiency virus[tw]))) OR (acquired immunodeficiency syndrome[tw] OR acquired immunedeficiency syndrome[tw] OR acquired immuno-deficiency syndrome[tw] OR acquired immune-deficiency syndrome[tw] OR ((acquired immun*) AND (deficiency syndrome[tw])))
#2	(genital ulcer) OR (genital ulcer disease) OR (genital ulcer diseases) OR (genital ulcers) OR (venereal disease) OR (venereal diseases) OR (venereal infections) OR (venereal infection)) OR ((sexually transmitted disease) OR (sexually transmitted diseases) OE sexually transmitted infection) OR (sexually transmitted infections)) OR ((bacterial sexually transmitted disease) OR viral sexually transmitted disease))
#3	#1 OR #2
#4	((randomized controlled trial [pt] OR controlled clinical trial [pt] OR randomized controlled trials [mh] OR random allocation [mh] OR double-blind method [mh] OR single-blind method [mh] OR clinical trial [pt] OR clinical trials [mh] OR ("clinical trial" [tw]) OR ((singl* [tw] OR doubl* [tw] OR trebl* [tw] OR tripl* [tw]) AND (mask* [tw] OR blind* [tw]))) OR ((placebos [mh] OR placebo* [tw] OR random* [tw] OR research design [mh:noexp] OR (comparative study) OR (comparative studies) OR (evaluation studies) OR (evaluation study) OR follow-up studies [mh] OR prospective studies [mh] OR control* [tw] OR prospectiv* [tw] OR volunteer* [tw])) NOT (animals [mh] NOT human [mh])
#5	(traditional medicine) OR native healer or native healers or aboriginal healer or aboriginal healers or indigenous healer or indigenous healers or traditional healer OR traditional healers
#6	#3 AND #4 AND #5 Limit: 1980:2008

4. AIDSearch Search Strategy

Number	**Search Terms**
#1	(hivinfections)orhivorhivorhiv-1*orhiv-2*orhiv1orhiv2or(hivinfect*)or(humanimmunodeficiencyvirus)or(human immunedeficiency virus) or (human immuno-deficiency virus) or (human immune-deficiency virus) or ((human immun*) and (deficiency virus)) or (acquired immunodeficiency syndrome) or (acquired immunedeficiency syndrome) or (acquired immuno-deficiency syndrome) or (acquired immune-deficiency syndrome) or ((acquired immun*) and (deficiency syndrome)) or (sexually transmitted diseases, viral)
#2	(viral sexually transmitted diseases) or (bacterial sexually transmitted diseases) or (sexually transmitted disease) or (sexually transmitted diseases) or (sexually transmitted infection) or (sexually transmitted infections) or (genital ulcer) or (genital ulcer disease) or (genital ulcer diseases) or (genital ulcers) or (venereal disease) or (venereal diseases) or (venereal infections) or (venereal infection)
#3	#1 OR #2

#4	((randomized controlled trial) or (controlled clinical trial) or (randomized controlled trials) or (random allocation) or (double-blind method) or (single-blind method) or (clinical trial) or (clinical trials) or ("clinical trial") or ((singl* or doubl* or trebl* or tripl* and (mask* or blind*)) or placebos or placebo* or random* or (comparative study) or (evaluation studies) or (follow-up studies) or (prospective studies) or control* or prospectiv* or volunteer*)) not (animals not human)
#5	(traditional medicine) or native healer or native healers or aboriginal healer or aboriginal healers or indigenous healer or indigenous healers or traditional healer or traditional healers
#6	#3 AND #4 AND #5 AND PY>=1980

5. Cochrane Library Search Strategy

Number	Search Terms
#1	(hivinfections)orhivorhivorhiv-1*orhiv-2*orhiv1orhiv2or(hivinfect*)or(humanimmunodeficiencyvirus)or(human immunedeficiency virus) or (human immuno-deficiency virus) or (human immune-deficiency virus) or ((human immun*) and (deficiency virus)) or (acquired immunodeficiency syndrome) or (acquired immunedeficiency syndrome) or (acquired immuno-deficiency syndrome) or (acquired immune-deficiency syndrome) or ((acquired immun*) and (deficiency syndrome)) or (viral sexually transmitted diseases), from 1980 to 2008
#2	(viral sexually transmitted diseases) or (bacterial sexually transmitted diseases) or (sexually transmitted disease) or (sexually transmitted diseases) or (sexually transmitted infection) or (sexually transmitted infections) or (genital ulcer) or (genital ulcer disease) or (genital ulcer diseases) or (genital ulcers) or (venereal disease) or (venereal diseases) or (venereal infections) or (venereal infection), from 2004 to 2008
#3	#1 AND #2
#4	(traditional medicine) or native healer or native healers or aboriginal healer or aboriginal healers or indigenous healer or indigenous healers or traditional healer or traditional healers, from 2004 to 2008
#5	#3 AND #4

Appendix 3

Quality Assessment of Included for Assessing Interventions for Educating Traditional Healers about STD & HIV Medicine

Quality Assessment for Peltzer et al., (2006)

Item	Judgement	Description
Baseline measurement	Yes	Traditional healer outcomes were measured prior to the intervention and there were no substantial differences.
Characteristics for studies using second site as control (CBA) or Concealment of allocation(CCTs)	No	There are significant differences between the control and the experimental group with regards to gender.
Blinded assessment of primary outcome(s) (protection against detection bias)	Unclear	The study did not specify whether the primary outcome measure was assessed blindly
Protection against contamination - Studies using second site as control	Yes	Cluster sampling was used to include all traditional healers from four selected communities
Reliable primary outcome measure(s)	No	The reliability of the measures were relatively low. HIV/AIDS knowledge-0.72; HIV/STI Management Practices-0.81; TB knowledge index-0.50; Risk Index-0.48.
Follow-up of professionals (protection against exclusion bias)	No	Of the 233 traditional healers in the study, 155 (67%) completed the 7–9 months follow-up interview; 66% intervention and 69% control

Quality Assessment for Poudyal et al., (2003).

Item	**Judgement**	**Description**
Baseline measurement	Unclear	The study did not indicate whether baseline measure were statistically different between the control and intervention group.
Characteristics for studies using second site as control (CBA) or Concealment of allocation(CCTs)	Unclear	Although characteristics are reported in the text, no data is presented.
Blinded assessment of primary outcome(s) (protection against detection bias)	No	The outcomes were not blindly assessed.
Protection against contamination - Studies using second site as control	Unclear	Participants in the study were randomly selected from a list of 10 village development committees. Therefore, communication between traditional healers in the experimental and control group was likely to occur.
Reliable primary outcome measure(s)	Unclear	Reliability was not reported for the outcome measures.
Follow-up of professionals (protection against exclusion bias)	Yes	Only 2 traditional healers did not complete the study.

Appendix 4

Interview Schedule for Predicting Referral Practices of Traditional Healers of Their Mentally Ill Adult and Adolescent Patients using The Theory of Planned Behaviour

THE SOUTH AFRICAN DEPRESSION AND ANXIETY GROUP

P O Box 652548 Benmore 2010
Tel: +27 11 783 1474
Fax: +27 11 884 7074
anxiety@iafrica.com
http://www.sadag.co.za/

Consent Form

Katherine Sorsdahl, a researcher at the University of Cape Town working with the South African Depression & Anxiety Group (SADAG) wants to get a better understanding about your referral practices of mentally ill patients, and your relationship with Western healthcare practitioners. We will be using this information to create workshops that will help Traditional Healers and Western Practitioners to work together more effectively in the future.

We would like you to talk with us about your referral practices of mentally ill patients. If you decide to participate in this interview:

1) We would like you to answer the questions as honestly as possible.
2) Your answers are completely private. Only the main researcher will see the answers you provide, and you will not be identified at any stage of the research. Your name and personal details will not be used. Your completed questionnaire will be stored in a locked room at the SADAG offices in Johannesburg.
3) You can choose not to answer any questions that you do not like
4) If you choose not to participate, there will be no bad feelings towards you. You will continue to receive all the support SADAG can give you.

I understand what this form is and agree to participate in the interview

Full Name: _____

Telephone Number: _____

Signature: _____

1. Are you a man or a woman? ☐ Man ☐ Woman

2. How old are you?_____

3. What kind of healer are you?

☐ Sangoma
☐ Inyanga
☐ Faith Healer
☐ Herbalist

4. How much school did you finish? _____

5. How long have you been a traditional healer for? _____

6. How long was your training? _____

7. How many patients do you see a week? _____

9. Have you ever referred a patient with a mental illness to a Western Doctor?

Yes ☐ No☐

9b. If yes, why did you decide to refer?

_____
_____
_____

10. Do you have at least one patient who is suffering from a mental illness now?

Yes ☐ No ☐

10a.If yes, please describe: history of patient/symptoms/what needs to be done?

_____
_____
_____

11. Are you going to refer this particular patient to a Western Doctor?
Yes ☐ No☐

12. How many patients do you see a month with a mental illness who are not violent or weak?
_____

12b. How many of these patients do you expect to refer to a Western doctor? _____

All of them ☐ Most of the them ☐ A little of the them ☐ None of them ☐

The questions I am going to ask you are all about the mentally ill patients you described that were not violent or weak.

(ENSURE THs UNDERSTAND THIS. IF UNCLEAR MENTION AFTER EVERY QUESTION!)

Please answer the following questions as honestly as possible:

1. Referring your mentally ill patient to a Western Doctor who is not responding to treatment is:

Very Useful ☐ Useful ☐ A Little Useful ☐ Not Useful At All ☐

2. People who mean a lot to you would like you to refer my mentally ill patient to the Western doctor if he/she is not responding treatment:

YES ☐ yes ☐ no ☐ NO ☐

3. Whether you refer your mentally ill patient who is not responding to treatment to a Western doctor is completely up to you:

NO ☐ no ☐ yes ☐ YES ☐

4. Referring your mentally ill patient to a Western doctor who is not responding to treatment is:

Very wrong ☐ Wrong ☐ A Little Bit Wrong ☐ Not Wrong at All ☐

5. Most people who are important to you think that you should refer your mentally ill patient to a Western doctor if they are not responding to treatment:

NO ☐ no ☐ yes ☐ YES ☐

6. For you to refer your mentally ill patient to a Western doctor is?

Very Difficult ☐ Difficult ☐ A Little Difficult ☐ Not Difficult At All ☐

7. Referring your patient to a Western Doctor is:

Very Foolish ☐ Foolish ☐ A little Foolish ☐ Not Foolish At All ☐

8. Referring your mentally ill patient who is not responding to treatment to a Western doctor is:

Very Good ☐ Good ☐ A Little Good ☐ Not Good At All ☐

9. It is expected of you to refer my mentally ill patients who are not responding to treatment to a Western doctor?

YES ☐ yes ☐ no ☐ NO ☐

10. For you to refer your mentally ill who is not responding to treatment to a Western doctor is?

Very Difficult ☐ Difficult ☐ A Little Difficult ☐ Not Difficult At All ☐

Please answer the following questions as honestly as possible:

11. Western doctors do not respect traditional healers:
Very True ☐ True ☐ A little true ☐ Not true at all ☐

12. When Western doctors do not respect traditional healers, how difficult is it to refer a patient:
Very Difficult ☐ Difficult ☐ A Little Difficult ☐ Not Difficult At All ☐

13. If I refer my mentally ill patient who is violently ill to a Western doctor they can give them medication to calm them down:
Very True ☐ True ☐ A little true ☐ Not true at all ☐

14. Giving a mentally ill patient medication to calm them down is:
Very Good ☐ Good ☐ A little good ☐ Not good at all ☐

15. People who mean a lot to you would like you to refer your mentally ill patients to the Western doctor:
YES ☐ yes ☐ no ☐ NO ☐

16. Whether you refer your mentally ill patients to a Western doctor is completely up to you:
NO ☐ no ☐ yes ☐ YES ☐

17. If you refer your mentally ill patient who is not eating and drinking to a Western doctor they can put them on a drip:
Very True ☐ True ☐ A little true ☐ Not true at all ☐

18. Putting mentally ill patients on a drip is:

Very Good ☐ Good ☐ A little good ☐ Not good at all ☐

19. Doing what the THO thinks you should do matters to you:
YES ☐ yes ☐ no ☐ NO ☐

22. Western doctors can only help patients who have a mental illness NOT caused by bewitchment:
Very True ☐ True ☐ A little true ☐ Not true at all ☐

23. Helping a mentally ill NOT caused by bewitchment is:
Very Bad ☐ Bad ☐ A little Bad ☐ Not Bad at all ☐

24. Unlike traditional medicine, Western medicine has side effects that can harm the patient:
Very True ☐ True ☐ A little true ☐ Not true at all ☐

25. Side effects that can potentially harm the patient are:
Very Good ☐ Good ☐ A little good ☐ Not good at all ☐

26. If you refer your mentally ill patient to a Western doctor, your patient can get a second opinion:
Very True ☐ True ☐ A little true ☐ Not true at all ☐

27. It is always good for the patient to get a second opinion:
Very True ☐ True ☐ A little true ☐ Not true at all ☐

28. The families of your patients approve of you referring your mentally ill patients to the Western doctor:
Always ☐ Most of the time ☐ A little of the time ☐ Not at all

29. Western doctors do not approve of your practices:
Very True ☐ True ☐ A little true ☐ Not true at all

30. When Western doctors do not approve of traditional healer practices, how difficult is it to refer a patient:
Very difficult ☐ Difficult ☐ A little difficult ☐ Not difficult at all ☐

31. Doing something good for a patient is:
Very Bad ☐ Bad ☐ A little Bad ☐ Not Bad at all ☐

32. Will you try to refer your mentally ill patients to a Western doctor if they do not respond to traditional treatments:
Always ☐ Most of the time ☐ A little of the time ☐ Not at all

33. The Traditional Healers Organization (THO) thinks that you should always refer your mentally ill patients to a Western doctor if they are not responding to treatment:
YES ☐ yes ☐ no ☐ NO ☐

34. If you refer your mentally ill patient to a Western doctor they may never be cured:
Very True ☐ True ☐ A little true ☐ Not true at all ☐

35. Africare would like you to refer your mentally ill patients to a Western doctor:
Always ☐ Most of the time ☐ A little of the time ☐ Not at all

36. Doing what Africare thinks you should do matters to you:
NO ☐ no ☐ yes ☐ YES

37. Do you plan to refer your mentally ill patients to a Western doctor if they do not respond to traditional treatments:
YES ☐ yes ☐ no ☐ NO ☐

38. Traditional healers often get blamed if patients die:
Very True ☐ True ☐ A little true ☐ Not true at all ☐

39. When Western doctors blame traditional healers when a patient dies, how difficult it is to refer a patient:
Very Difficult ☐ Difficult ☐ A Little Difficult ☐ Not Difficult At All ☐

40. Western doctors do not think your medications are useful:
Very True ☐ True ☐ A little true ☐ Not true at all ☐

41. When Western doctors do not think traditional healer medication is useful, how difficult is it to refer a patient:
Very Difficult ☐ Difficult ☐ A Little Difficult ☐ Not Difficult At All ☐

42. Western doctors do not have time to give the patient the attention they need:
Very True ☐ True ☐ A little true ☐ Not true at all ☐

43. When a patient does not get the attention they need it is:
Very Bad ☐ Bad ☐ A little Bad ☐ Not Bad at all ☐

44. Are you confident that you could refer your mentally ill patients to a Western doctor if you wanted to:
YES ☐ yes ☐ no ☐ NO ☐

45. Not being able to cure a mentally ill patient is:
Very Good ☐ Good ☐ A little good ☐ Not good at all ☐

Please answer the following questions, with a yes or no answer

46. Some of the symptoms a mentally ill patient suffers from can be:

a. Hear voices	☐ Yes	☐ No
b. Have problems breathing	☐ Yes	☐ No
c. Have a tumor	☐ Yes	☐ No
d. Crying all the time	☐ Yes	☐ No
e. Have tried to kill themselves	☐ Yes	☐ No
f. Thinking about death and suicide	☐ Yes	☐ No
g. They throw things around violently	☐ Yes	☐ No
h. They are very stressed	☐ Yes	☐ No
i. They have been sad for more than 2 weeks	☐ Yes	☐ No
j. Feel like they are being watched all the time	☐ Yes	☐ No
k. They have lost or gained a lot of weight	☐ Yes	☐ No
l. they have problems sleeping	☐ Yes	☐ No
m. they are thinking too much	☐ Yes	☐ No

Thank you for taking the time to complete this questionnaire!